PALMETTO GBA®

A CELERIAN GROUP COMPANY

A CMS Medicare Administrative Contractor

Direct Data Entry (DDE) User's Manual

September 2015

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This publication was current at the time it was published. Medicare policy may change so links to the source documents have been provided within the document for your reference.

This publication was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Any changes or new information superseding the information in this manual are provided in the Medicare Part A and Home Health and Hospice (HHH) Bulletins/Advisories with publication dates after August 2015. Medicare Part A and HHH Bulletins/Advisories are available at www.PalmettoGBA.com/medicare.

SECTION 1 – INTRODUCTION

Direct Data Entry (DDE) Online Remote Terminal Access was designed as an integral part of the Fiscal Intermediary Standard System (FISS). It gives Medicare providers direct access to information on their claims. The FISS is a menu driven system. The menu item chosen determines the system's functional capability. The Main Menu includes the following sub-menus: Inquiry, Claim Entry and Attachment, Claim Correction and Online reports. A DDE Medicare provider may perform the following functions electronically:

- Submit UB-04 claims
- Correct, adjust, and cancel claims
- Perform inquiries such as beneficiary eligibility, claims history, revenue codes, diagnosis codes, etc.
- View certain online reports

Provider Contact Center Numbers

Please check this user's manual for answers to your question before you contact Customer Support. The guidelines in the manual may answer your question and eliminate the need for you to contact a Customer Support Representative. For questions and information not covered in this manual, please call the Provider Contact Center at 855-696-0705.

Keyboard

The following table provides an overview of common keyboard commands and their respective functions, and language related to navigating the DDE system.

Command/Term	Function
Cursor	The cursor is the flashing underline that identifies where you are (in what field you are located) on the screen.
↑ ← → ↓	Use the keyboard arrow keys to move one character at a time in any direction within a field.
[TAB]	Press the tab key to advance to the next field.
[SHIFT]-[TAB]	Press and hold down the **SHIFT** key, while you press the **TAB** key to move back to the previous field. When your cursor is in the top field, this **[SHIFT]-[TAB]** will move your cursor to the bottom field.
n	In examples shown in this manual, an **'n'** indicates a variable number from 0 to 9. One or more numbers may show as variables. For example, '72n' represents the numbers 720-729, while '72nnn' represents the numbers 72000-72999.
[CTRL]-[R]	If your screen freezes or locks up, press and hold down the **Control key**, while you press the letter '**R**'. This will reset the screen. Note: Do not use this key combination if you see the clock symbol '(X)' displayed at the bottom of the screen (see next term).
(X) ⊕	One of these clock symbols displays at the bottom of the screen when the system is processing your request. Do not press any key until the symbol goes away and the blinking cursor returns.
[END]	Press the **[END]** key to clear, or delete, the value in a field. Do not use the spacebar to clear a field, as spaces may be recognized as a character in FISS

Keyboard Function Keys

The keyboard function keys (also referred to as Program Function keys), are used to initiate the functions as specified in the following table. Your keyboard may identify these keys as [PF1], [PF2], [PF3], etc. or as [F1], [F2], [F3], etc.

Function Key	Function
[F1]	**The FISS Help Function –** Press [F1] to obtain a description of a reason code.
[F2]	**Revenue Code Jump –** From claim page 2 (MAP1712), press [F2] to jump to MAP171D for the first Revenue Code in error. Also, if your cursor is placed on a specific Revenue Code line on page 2, press [F2] to jump to the same Revenue Code on MAP171D.
[F3]	**Exiting a Claim, Menu or Submenu –** Depending on the location of the cursor in the system, press [F3] to exit a claim, menu or submenu and return to the previous screen.
[F4]	**Exiting the System –** Pressing [F4] exits the entire system or terminates the session. After pressing [F4], type 'CSSF LOGOFF' and then press [ENTER] to complete the exit process.
[F5]	**Scrolling Backwards in a Screen Page –** Not all information on a page may be seen on the screen at one time. To review hidden data from the same screen page, press [F5] to scroll backwards.
[F6]	**Scrolling Forward in a Screen Page –** To view hidden data from the same screen page, press [F6] to scroll forward.
[F7]	**View Previous Page –** Press [F7] to review a previous page or move backward one page at a time.
[F8]	**Page Forward –** Press [F8] to view the next page or to move forward one page at a time.
[F9]	**Updating Data –** Due to the system's design, a claim will not be accepted until either all front-end edits are corrected or the system is instructed to reject or return the claim. By pressing [F9], the system will return claim errors for correction and update and store data entered while in the entry or correction transaction mode.
[F10]	**Scroll Left –** Moves left to columns 1-80 within a claim record. This also allows access to the last page of beneficiary history when in claim summary by HIC.
[F11]	**Scroll Right –** Moves right to columns 81-132.

Status/Location Codes

The Status/Location (S/LOC) code for Medicare DDE screens indicates whether a particular claim is paid, suspended, rejected, returned for correction, etc. The six-character alphanumeric code is made up of a combination of four sub-codes: the claim status, processing type, location, and additional location information. Each S/LOC code is made up of two alpha characters followed by four numeric characters. For example, P B9997 is a status location code.

- The first position (position a) is the claim's current status. In this example 'P' indicates that the claim has been *paid* (or *partially paid*).
- The second position (position b) is the claim processing type. In the example, 'B' indicates *batch*.
- The third and fourth positions (positions cc) are the location of the claim in FISS. In the example, '99' indicates that the *session terminated*, which essentially means that the processing of the claim is completed.
- The last two positions (positions dd) are for additional location information. In the example, '97' indicates that the provider's claim is *final on-line*.

A provider may perform certain transactions when there is a specific S/LOC code on the claim. Other transactions cannot be done at all with certain S/LOC codes. The following table provides descriptions of the S/LOC code components.

FISS S/LOC Codes			
Status (Position a)	**Processing Type (Position b)**	**Driver Location (Positions cc)**	**Location (Positions dd)**
A = Good I = Inactive S = Suspense M = Manual Move P = Paid/Partial Pay R = Reject D = Deny T = RTP U = Ret to PRO	M = Manual O = Off-line B = Batch	01 = Status/Location 02 = Control 04 = UB-04 Data 05 = Consistency (I) 06 = Consistency (II) 15 = Administrative 25 = Duplicate 30 = Entitlement 35 = Lab/HCPC 40 = ESRD 50 = Medical Policy 55 = Utilization 60 = ADR 63 = HHPPS Pricer 65 = PPS/Pricer 70 = Payment 75 = Post Pay 80 = MSP Primary 85 = MSP Secondary 90 = CWF 99 = Session Term AA-ZZ = User defined	00 = Batch Process 01 = Common 02 = Adj. Orbit 10 = Inpatient 11 = Outpatient 12 = Special Claims 13 = Medical Review 14 = Program Integrity 16 = MSP 18 = Prod. QC 19 = System Research 21 = Waiver 65 = Non DDE Pacemaker 66 = DDE Pacemaker 67 = DDE Home Health 96 = Payment Floor 97 = Final Online 98 = Final Off-line 99 = Final Purged/ Awaiting CWF Response 22-64 = User defined 68-79 = User defined AA-ZZ = User defined

Document Control Number (DCN)

The DCN number is located on the remittance advice. This number must be used with adjustment/ cancellation bills.

Field Position	Field	Definition
1 - 1	Century Code	Code used to indicate the century in which the DCN was established. Valid values include: 1 = 1900-1999 2 = 2000 +
2 - 3	Year	The last two digits of the year during which the claim was entered. This is system generated.
4 - 6	Julian Date	Julian days corresponding to the calendar entry date of the claim. This is system generated.
7 - 10	Batch Sequence	Primary sequencing field, beginning with 0000 and ending with 9999. This is system generated with automated DCN assignment.
11 - 12	Claim Sequence	Secondary sequencing field, beginning with 00 and ending with 99.
13	Choices/Split	Site-specific field used on split bills. Valid values include: C = Medicare Choices Claim E = ESRD Managed Care V = VA Demo P = Encounter Claim 0 = When not used at a site

Field Position	Field	Definition
14	Origin	Code designating method of claim entry into the system. Valid values are: 0 = Unknown 1 = EMC/UB-04/CMS Format 2 = EMC Tape/UB-04/Other Format 3 = EMC Tape/Other ('Other' is defined as PRO Automated Adjustment for FISS) 4 = EMC Telecom/UB-04 (DDE Claim) 5 = EMC Telecom/Not UB-04 6 = Other EMC/UB-04 7 = Other EMC/Not UB-04 8 = UB-04 Hardcopy 9 = Other Hardcopy
15 - 17	Business Segment Identifier (BSI)	This is a three-position alphanumeric field. The first two characters are the jurisdiction code: For Fiscal Intermediary, Carrier and Regional Home Health Intermediary Workloads, the code is the Official United States Postal Service (USPS) state abbreviation for the state jurisdiction. For Durable Medical Equipment Regional Carriers, these two positions identify the DME region, for example Region A is RA. The next character identifies the type of Medicare FFS contract: Fiscal Intermediary (A), Carrier (B), Regional Home Health Intermediary (R), or Durable Medical Equipment Regional Carrier (D).
18 – 21	Home Health Split/ Mass Adjustment/Future Area	Home Health Split: 'D' The DCN number has been altered due to a file fix to make the DCN unique 'H' In first position, system generated Trailer 15 or 16 adjustment 'P' In first position, system generated Post Pay activity 'R' In the first position, system generated Trailer 24 with a mask of 'O' for interrupted stay 'Q' Demo Code 62/63 and Qualifying Stay 'T' Unsolicited Adjustments 'U' Unsolicited Trailer 24 Responses 'Z' In first position, system generated for trailer '24' with mask 'N', adjustment for incorrect patient status on IPPS claims Mass Adjustment: User defined Future Area: positions 16 -21 reserved for future use
22-23	N/A	Reserved for future use

SECTION 2 – CONNECTION INSTRUCTIONS

Palmetto GBA's DDE system includes the **Jurisdiction M Region** (JM MAC FISS PROD). The Jurisdiction M MAC FISS PROD processing region consists of the following states:

Part A	Home Health / Hospice (HHH)		
North Carolina	Alabama	Indiana	North Carolina
South Carolina	Arkansas	Kentucky	Ohio
Virginia	Florida	Louisiana	Oklahoma
West Virginia	Georgia	Mississippi	South Carolina
	Illinois	New Mexico	Tennessee
			Texas

Connection Procedures

Once you have a connection established using the instructions provided by your Network Service Vendor, the Product Selection Screen will display.

JURISDICTION M SIGN-ON

A. At the **PRODUCT SELECTION** screen, your cursor will be positioned at the arrow (===>) in the lower left hand corner. Select the number corresponding to **A3PTPX** and press **[ENTER]**.
B. The TPX Sign-On screen (Figure 1) will display.

Figure 1 – CICS Sign On Screen

1. At the USERID prompt, type your DDE User ID and press **[TAB]**. DDE User ID numbers are assigned to individuals at each facility who utilize the DDE system.
2. At the PASSWORD prompt, type in your password and then press **[ENTER]**.

If this is your first time logging on using your new DDE User ID, use the default password that was included in your EDI confirmation.

As you enter your default password, nothing will show on the screen but you will see the cursor move to the right. After you press [ENTER], the system will prompt you to change the password. Follow the directions noted on the screen regarding password requirements when changing your password.

Note: Your password will expire every 30 days and you must make at least 12 password changes before you can repeat a previously used password. If you receive a notice that your password has **expired**, please follow the directions noted on the screen when changing your password. If you receive a notice that your password has been **revoked**, please refer to the Changing Passwords section. If you have not used DDE for several months, it may be automatically revoked and please contact the Palmetto GBA EDI Technology Support Center toll-free at 855-696-0705 for assistance.

After you correctly enter your User ID and password, the TPX Menu Screen (Figure 2) will display.

Figure 2 – TPX Menu Screen

- **North Carolina providers** should select the **JM MAC FISS Prod – N. Carolina** session from the menu by entering S on the green line. Then press **[ENTER]**.
- **South Carolina Part A and HHH providers** should select the **JM MAC FISS PROD – SC/HHH** session from the menu by entering S on the green line. Then press **[ENTER]**.
- **Virginia and West Virginia Part A providers** should select the **JM MAC FISS PROD – VA/WV** session from the menu by entering S on the green line. Then press **[ENTER]**.

Final Connectivity Instructions

Instructions listed below are for all providers:

1. Type **FSS0** (F, S, S, zero) directly over the screen message and press **[ENTER]**.
   Note: You must type a *numeric zero* when typing in FSS0. If you accidentally type an alpha 'O', the system will give you an error message.
2. The Main Menu (Figure 3) will display. From the Main Menu, you may select the function you wish to perform on the DDE system. Refer to the appropriate section of this manual for the function you wish to use.

Figure 3 – The Main Menu

Sign-Off Procedures

To end communication between your terminal and Palmetto GBA's host system (FISS), you must sign off. The terminal will sign off automatically when the network is disabled.

To help the computer function at optimum speed, always sign off completely and correctly when you are not using the system.

1. Press **[F3]** from the Main Menu.
2. The screen will display SESSION SUCCESSFULLY TERMINATED.

Jurisdiction M Sign-Off

A. Type '**CESF LOGOFF**' over the message and press **[ENTER]**.
B. Type **/K** to sign-off from the TPX Menu Screen and press **[ENTER**].

3. Pull down the **Terminal** menu from the toolbar and select **Disconnect**.
4. Pull down the **Terminal** menu again and select **Close**.

Changing Passwords

Jurisdiction M Providers

Your password will expire every thirty days. On the day after it expires, when you type your password, the system will automatically prompt you to change your password. Rules for passwords will display on the system when you change your password.

To change your password, follow these steps:

1. When you log on for the first time or after your password has expired, you will enter your user ID and your existing (or default) password. After pressing [ENTER], the system will display the message, "Your password has expired. Please enter your new password." The screen will now contain one 'New Password' field.
2. Your cursor will be located in the 'New Password' field. Type in your new password. Nothing will show on the screen as you type but you will see the cursor move to the right. After you have finished typing, press **[ENTER]**.

3. Verify your new password by typing it identically again in the same 'New Password' field and press **[ENTER]**.
4. The system displays the TPX Menu Screen. Follow via the instructions in Section 2 – Connection Instructions above to complete your sign-on.
   Note: If you receive a notice that your password has been revoked, a password utility has been provided for your own password resets. Follow the instructions listed below:
   a. Proceed to the CDS EDC TPX session screen.
   b. Press **[F5]** as shown on the menu at the bottom of screen. The Self-Service Password Reset screen appears and prompts you to key in a valid RACF ID and PIN.
   c. Press **[ENTER]**.
   d. A message will appear at the bottom of screen providing the new temporary password. Press **[F12]** to return to the TPX sign on screen.
      Once returned to the TPX session sign-on screen, you can now sign-on using the new temporary password.
      - The password length must be eight (8) characters.
      - Passwords must have at least one (1) of these special characters: @, # or $.
      - Passwords must start with a letter and must have at least one (1) number and one (1) letter (not a number of special characters).

      NOTE: A password can only be reset by the user with this process once in a 24-hour period.

SECTION 3 – MAIN MENU

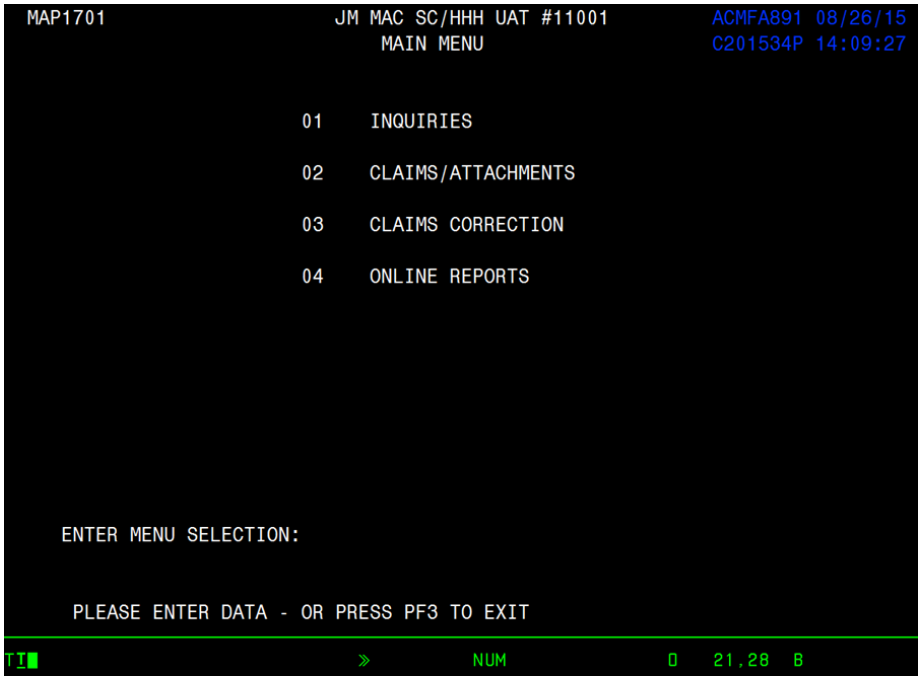


Figure 4 – The Main Menu

The DDE Online system includes the Main Menu (Figure 4) that displays after completing the logon procedure. Each menu option from the Main Menu displays a sub-menu for that option.

The Inquiries (01), Claims/Attachments (02), Claims Correction (03) sub-menus, and Online Reports (04) are explained in the following sections.

SECTION 4 – CLAIM INQUIRY

The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, you will need to change the National Provider Identifier (NPI) number to inquire or input information. [TAB] to the NPI field on the respective screen and type in the appropriate number. To access the Inquiry Menu, select option 01 from the Main Menu.

THE INQUIRY MENU (MAP1702) - INFORMATION ON EACH OF THE INQUIRY MENU OPTIONS FOLLOWS.

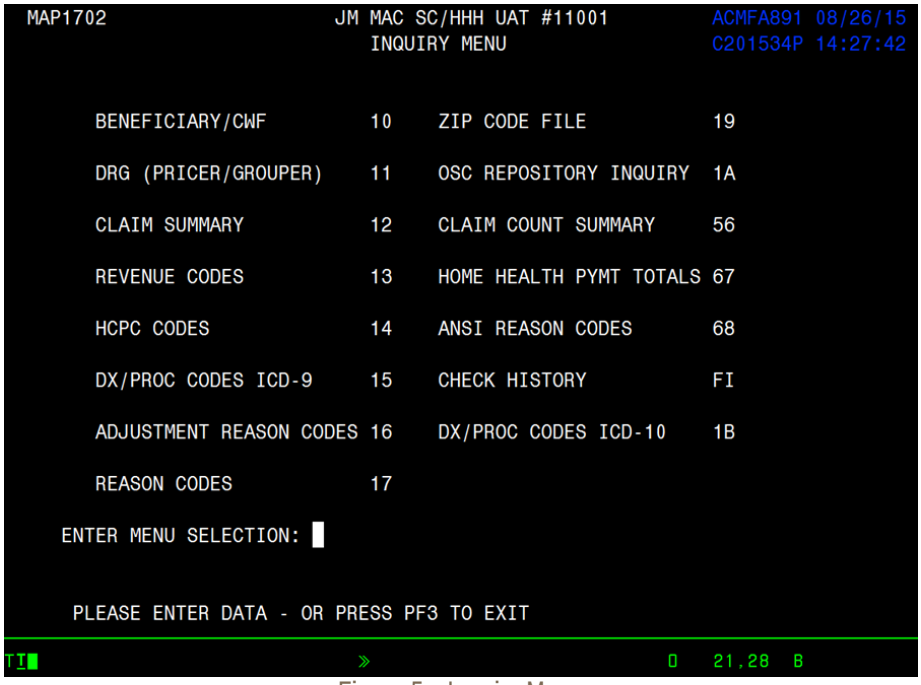


Figure 5 – Inquiry Menu

The screens displayed from each of the options on the inquiry menu screen will display the 'SC' field on the upper left side of the screen. The SC field is defined as the scroll function, which is a two-digit field in which you can enter the number from the inquiry menu screen that you want to access. **Using the scroll function eliminates the need to exit to the menu each time you are ready to proceed to the next inquiry screen.** For example, from any of the Beneficiary CWF screens, you can enter '10' in the SC field to move to the DRG (Pricer/Grouper) screen instead of hitting the [F3] key to return to the inquiry menu to get to the DRG (Pricer/Grouper) screen.

Beneficiary/CWF

Select option '10' from the Inquiry Menu to access the Beneficiary/CWF screens. These screens display current Medicare Part A and Part B entitlement and utilization information about a specific beneficiary.

There are several pages (screens) of eligibility information:

- Screen1 (MAP1751): Patient eligibility information in the FISS
- Screen 2 (MAP1752): Patient eligibility information in the FISS
- Screen 3 (MAP175A): Patient eligibility information in the FISS
- Screen 4 (MAP175J): Patient eligibility information on preventative care in the FISS
- Screen 5 (MAP175M): Patient eligibility information on preventive HCV screening
- Screen 6 (MAP1755): Patient hospital eligibility information
- Screen 7 (MAP1756): Patient HMO Enrollment and other eligibility information

- Screen 8 (MAP1757): Patient PAP and Mammography eligibility information
- Screen 9 (MAP1758): Patient Hospice Benefit periods 1 and 2
- Screen 10 (MAP175C): Patient Hospice Benefit periods 3 and 4
- Screen 11 (MAP175K): Patient Smoking and Tobacco Use Cessation Counseling Services
- Screen 12 (MAP175L): Patient Home Health certification information

To begin the inquiry process, enter the following information on screen 1 **as it appears on the patient's Medicare card**:

- Health Insurance Claim (HIC) number
- Last name & first initial
- Sex (M or F)
- Date of birth (in MMDDYYYY format)

[TAB] to move between fields on the screen. *Only press* **[ENTER]** *when all fields have been completed.*

Beneficiary/CWF Screens

Screen 1 (MAP1751) – Field descriptions are provided in the table following Figure 6.

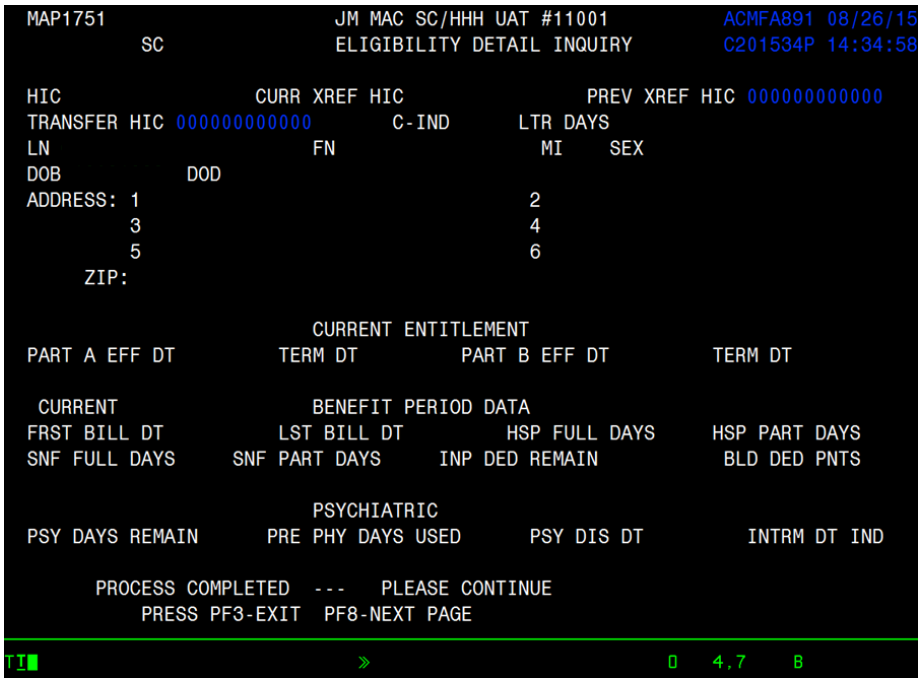


Figure 6 – Beneficiary/CWF Screen 1

Field Name	Description
HIC	Type the patient's health insurance claim (HIC) number as it appears on the Medicare ID card.
CURR XREF HIC	If the HIC number has changed for the beneficiary/patient, this field represents the most recent number (the HIC number as returned by CWF).
PREV XREF HIC	This field is no longer in use.
TRANSFER HIC	This field is no longer in use.
C-IND	Century Indicator – This field represents a one-position code identifying if the patient's date of birth is in the 18th, 19th or 20th century. Valid values are: 8 = 1800s 9 = 1900s 2 = 2000s
LTR DAYS	The lifetime reserve days remaining.
LN	The patient's last name.

Field Name	Description
FN	The patient's first name.
MI	The patient's middle initial.
SEX	The patient's sex.
DOB	The patient's date of birth in MMDDYYYY format.
DOD	The patient's date of death.
ADDRESS (1 – 6)	The patient's street address, city, and state of residence.
ZIP	The zip code for state of residence.
Current Entitlement	
PART A EFF DT	The date a beneficiary's Medicare Part A benefits become effective.
TERM DT	The date a beneficiary's Medicare Part A benefits were terminated.
PART B EFF DT	The date a beneficiary's Medicare Part B benefits became effective.
TERM DT	The date a beneficiary's Medicare Part B benefits were terminated.
Current Benefit Period Data	
FRST BILL DT	The beginning date of inpatient benefit period.
LST BILL DT	The ending date of inpatient benefit period.
HSP FULL DAYS	The remaining full hospital days.
HSP PART DAYS	The remaining hospital co-insurance days.
SNF FULL DAYS	The full days remaining for a skilled nursing facility.
SNF PART DAYS	The partial days remaining for a skilled nursing facility.
INP DED REMAIN	The Part A inpatient deductible amount the beneficiary must pay.
BLD DED PNTS	The remaining blood deductible pints.
Psychiatric	
PSY DAYS REMAIN	The remaining psychiatric days.
PRE PHY DYS USED	Number of pre-entitlement psychiatric days the beneficiary has used.
PSY DIS DT	Date patient was discharged from a level of care.
INTRM DT IND	Code that indicates an interim date for psychiatric services. Valid values are: Y = Date is through date of interim bill/utilization day N = Discharge date / not a utilization day

Screen 2 (MAP1752) – Field descriptions are provided in the table following Figure 7.

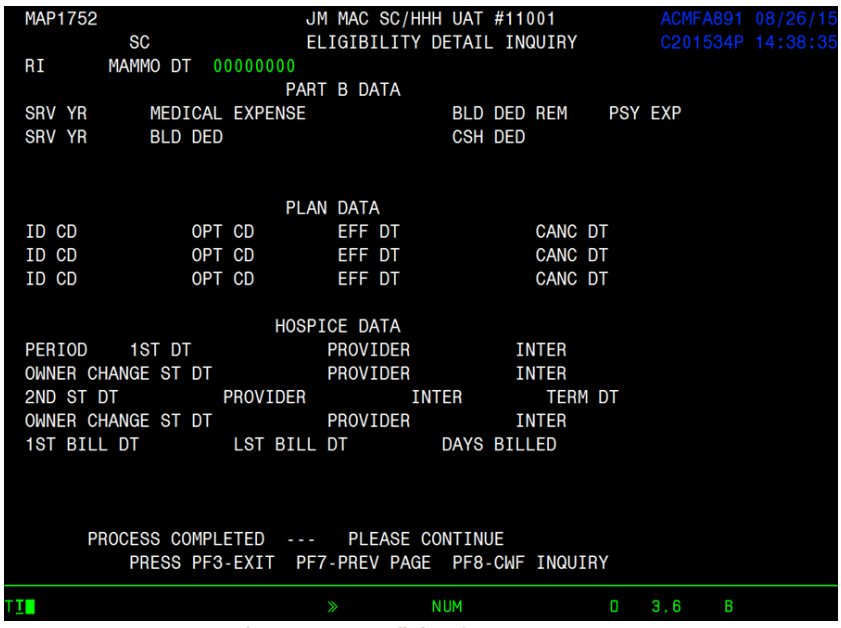


Figure 7 – Beneficiary/CWF Screen 2

Field Name	Description
RI	In DDE/CWF this Reason for Inquiry field is hard-coded with a '1' needed for HIQA Inquiry. Valid values are: 1 = Inquiry 2 = Admission Inquiry
MAMMO DT	Mammography Date.
Part B Data	
SRV YR	The calendar year for current Medicare part B services that are associated with the cash deductible amount entered in the Medical Expense field.
MEDICAL EXPENSE	The cash deductible amount satisfied by the beneficiary for the service year.
BLD DED REM	The remaining of pints of blood to be met.
PSY EXP	The dollar amount associated with psychiatric services.
SRV YR	The calendar year for current Medicare Part B services that are associated with the cash deductible amount entered in the Medical Expense field and with the Blood Deductible field.
BLD DED	This field is no longer applicable.
CSH DED	This field is no longer applicable.
Plan Data	
ID CD	**Plan Identification Code -** This field identifies the Plan Identification code for beneficiaries who are enrolled in a Medicare Advantage (MA) Plan (otherwise known as a Medicare HMO plan). This is a five-position alphanumeric field. This field occurs three times. The structure of the identification number is: Position 1 H Position 2 & 3 State Code Position 4 & 5 Plan number within the state
OPT CD	This field identifies whether the current Plan services are restricted or unrestricted. Valid values are: **Unrestricted—Cost-based plans** 1 = Medicare contractor to process all Part A and B provider claims. 2 = Plan to process claims for directly provided service and for services from Providers with effective arrangements. **Restricted—Risk-based Plans** A = Medicare contractor to process all Part A and B provider claims. B = Plan to process claims only for directly provided services. C = Plan to process all claims.
EFF DT	The effective date for the Plan benefits.
CANC DT	The termination date for the Plan benefits.
Hospice Data	
PERIOD	Specific Hospice election period. Valid values are: 1 = The first time a beneficiary uses Hospice benefits. 2 = The second time a beneficiary uses Hospice benefits.
1ST DT	First Hospice Start Date (in MMDDYY format) of the beneficiary's effective period (1-4) with the Hospice Provider.
PROVIDER	Identifies the hospice's six-digit Medicare provider number.
INTER	Identifies the Medicare contractor number for the hospice provider.
OWNER CHANGE ST DT	The Change of Ownership Start Date field will display the start date of a change of ownership within the period for the first provider.
PROVIDER	The number of the Medicare hospice provider.
INTER	The Medicare contractor number for the hospice Provider.
2ND ST DT	A 6-character field that identifies the start date for each 2nd hospice period (1-4).
PROVIDER	Identifies the hospice's Medicare provider number.
INTER	Identifies the Medicare contractor number for the hospice provider.
TERM DT	A 6-digit numeric field that identifies each termination date for hospice services for this hospice Provider (1-4).
OWNER	Displays the start date of a change of ownership within the period for the second

Field Name	Description
CHANGE ST DT	provider.
PROVIDER	Identifies the hospice's Medicare provider number.
INTER	Identifies the Medicare contractor number for the hospice provider.
1ST BILL DT	A 6-digit numeric field (in MMDDYY format) that identifies the date of each earliest hospice bill.
LST BILL DT	A 6-digit numeric field (in MMDDYY format) that identifies each most recent hospice date.
DAYS BILLED	A 3-digit numeric field that identifies the cumulative number of days billed to date for the beneficiary under each hospice election.

Screen 3 (MAP175A) –description of this screen is provided following Figure 8.

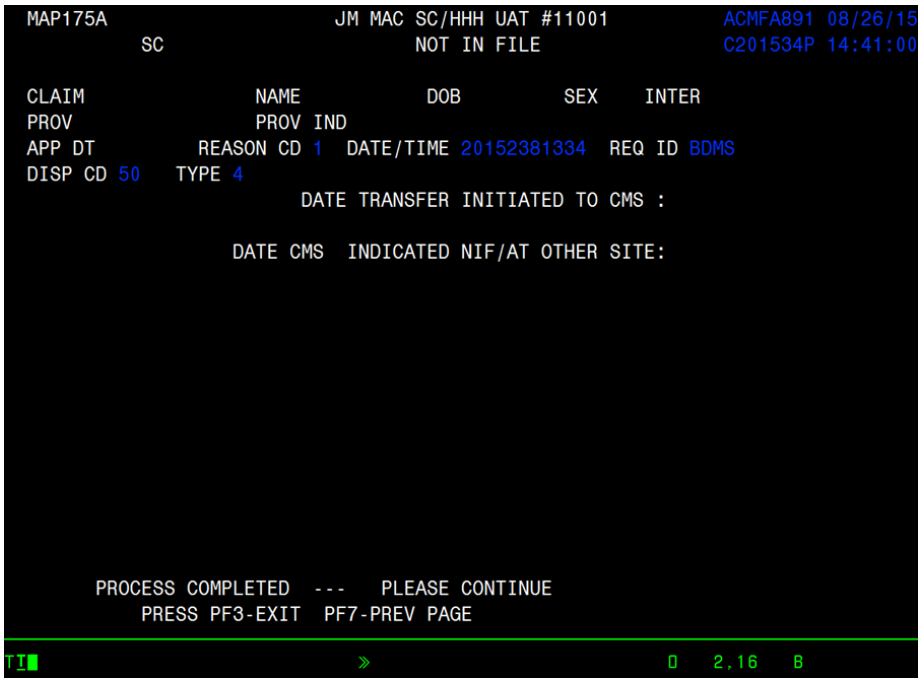


Figure 8 – Beneficiary/CWF Screen 3

Field Name	Description
CLAIM	The beneficiary's Health Insurance Claim Number (HICN) as shown on the Medicare card.
NAME	Beneficiary's first initial and last name.
DOB	Beneficiary's date of birth.
SEX	Beneficiary's Sex. Valid values are: 'F' – Female 'M' – Male
INTER	The provider's Medicare Contractor number.
PROV	The Provider's Medicare billing number. This is a six-digit number.
PROV IND	This field identifies the provider number indicator. Valid values are: ' ' – The provider number is a Legacy or OSCAR number 'N' – The provider number is an NPI number
APP DT	This field is used for spell determination, such as the admission date and current date. MMDDYY format.
REASON CD	This field identifies the reason for the inquiry. Valid values are: '1' – Status inquiry '2' – Inquiry related to an admission
DATE/TIME	This field identifies the date and time the request was made. Julian date format.
REQ ID	**Requester ID** - This field identifies the individual who submitted the inquiry.

Field Name	Description
DISP CD	**CWF Disposition Code** – This field identifies a code assigned when the request is processed through the CWF host site.
TYPE	This field identifies the type of reply from CWF. Valid value is '4' – Not in File.
DATE TRANSFER INITIATED TO CMS	This field identifies the first date the transfer was initiated to CMS.
DATE CMS INDICATED NIF/AT OTHER SITE	This field identifies the date CMS indicated the beneficiary HIC was not in file at another site. MMDDYY format.

Screen 4 (MAP175J) – Field descriptions are provided in the table following Figure 9.

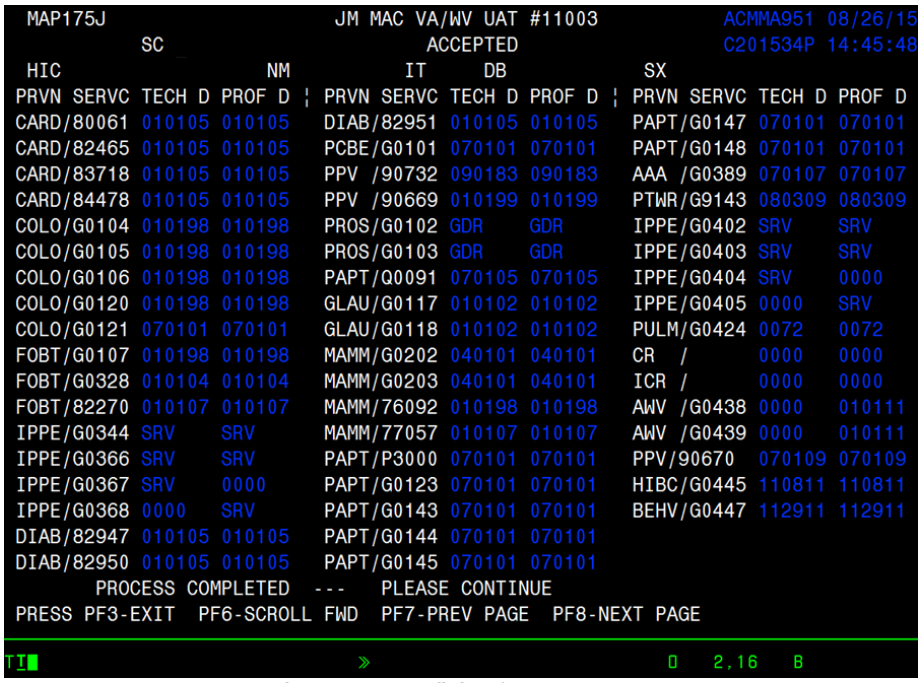


Figure 9 – Beneficiary/CWF Screen 4

Field Name	Description
HIC	The beneficiary's Medicare number as it appears on the Medicare ID card.
NM	The beneficiary's last name.
IT	The initial of the beneficiary's first name.
DB	The beneficiary's date of birth (in MMDDYY format).
SX	The beneficiary's sex. Valid values are: F = Female M = Male
PRVN SRVC	This field identifies the preventative service category.
TECH D	**Technical Date** - This field identifies the date the beneficiary is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary is not eligible. Valid values are: ▪ PTB =Beneficiary is not entitled to Part B ▪ RCVD = Beneficiary already received service ▪ DOD = Beneficiary not eligible due to date of death ▪ GDR = Beneficiary not eligible due to gender ▪ AGE = Beneficiary not eligible due to age

Field Name	Description
	▪ SRV = Beneficiary not eligible for the service ▪ VAC = Beneficiary already vaccinated ▪ Service not applicable
PROF D	**Professional Date** - This date identifies the date the beneficiary is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary is not eligible. Valid values are: ▪ PTB =Beneficiary is not entitled to Part B ▪ RCVD = Beneficiary already received service ▪ DOD = Beneficiary not eligible due to date of death ▪ GDR = Beneficiary not eligible due to gender ▪ AGE = Beneficiary not eligible due to age ▪ SRV = Beneficiary not eligible for the service ▪ VAC = Beneficiary already vaccinated ▪ Service not applicable

Screen 5 (MAP175M) – Field descriptions are provided in the table following Figure 10.

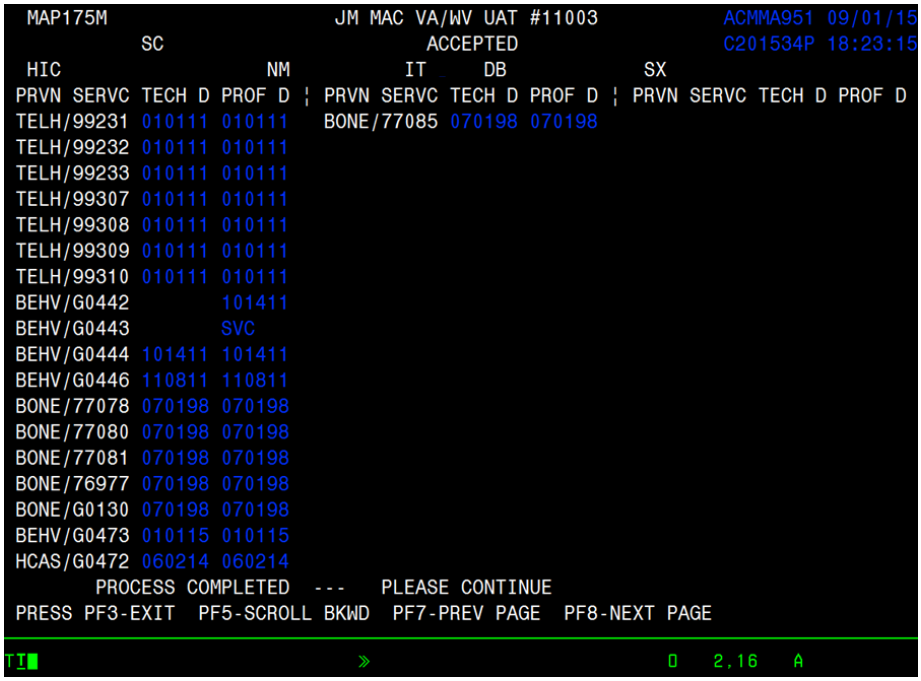


Figure 10 – Beneficiary/CWF Screen 5

Field Name	Description
HIC	The beneficiary's Medicare number as it appears on the Medicare ID card.
NM	The beneficiary's last name.
IT	The initial of the beneficiary's first name.
DB	The beneficiary's date of birth (in MMDDYY format).
SX	The beneficiary's sex. Valid values are: F = Female M = Male
PRVN SRVC	This field identifies the preventative service category.

Field Name	Description
TECH D	**Technical Date** - This field identifies the date the beneficiary is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary is not eligible. Valid values are: ▪ PTB =Beneficiary is not entitled to Part B ▪ RCVD = Beneficiary already received service ▪ DOD = Beneficiary not eligible due to date of death ▪ GDR = Beneficiary not eligible due to gender ▪ AGE = Beneficiary not eligible due to age ▪ SRV = Beneficiary not eligible for the service ▪ VAC = Beneficiary already vaccinated ▪ Service not applicable
PROF D	**Professional Date** - This date identifies the date the beneficiary is eligible for preventative service coverage. **Note**: When there is not a date, one of the following messages displays to explain why the beneficiary is not eligible. Valid values are: ▪ PTB =Beneficiary is not entitled to Part B ▪ RCVD = Beneficiary already received service ▪ DOD = Beneficiary not eligible due to date of death ▪ GDR = Beneficiary not eligible due to gender ▪ AGE = Beneficiary not eligible due to age ▪ SRV = Beneficiary not eligible for the service ▪ VAC = Beneficiary already vaccinated ▪ Service not applicable

Screen 6 (MAP1755) – Field descriptions are provided in the table following Figure 11.

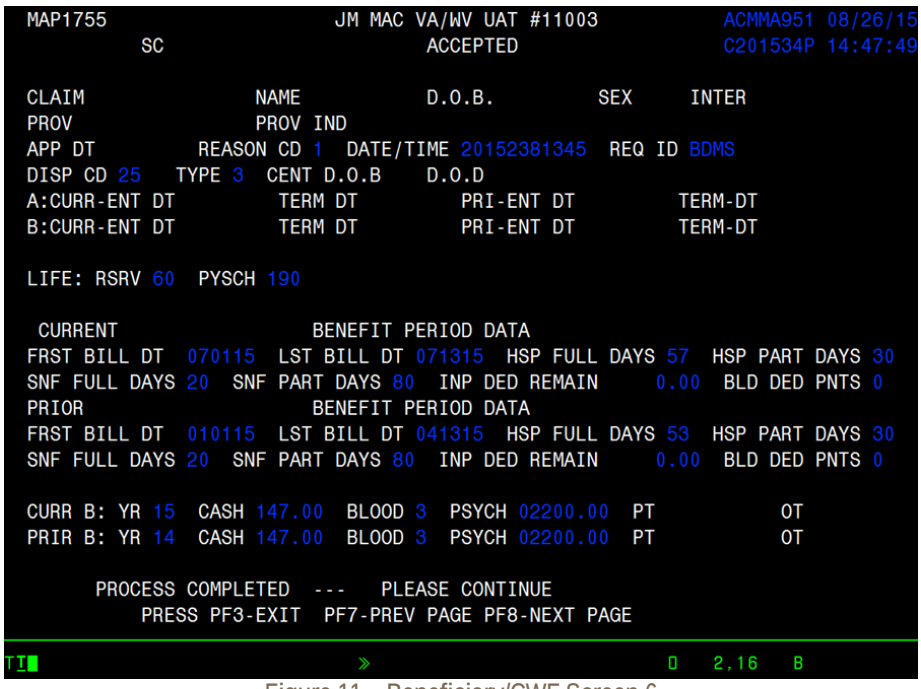


Figure 11 – Beneficiary/CWF Screen 6

Field Name	Description
CLAIM	The beneficiary's Medicare number as it appears on the Medicare ID card.
NAME	The beneficiary's first initial and last name.
D.O.B	The beneficiary's date of birth (in MMDDYY format).

Field Name	Description
SEX	Valid values are: F = Female M = Male U = Unknown
INTER	The Medicare contractor number for the Provider.
PROV	The CMS-assigned identification number of the institution that rendered services to the beneficiary/patient. It is system generated for external operators that are directly associated with one Provider (as indicated on the operator control file).
PROV IND	**Provider Indicator –** This field identifies the provider number indicator. This is a one-digit alphanumeric field. The valid values are: ' ' = The provider number is a Legacy or OSCAR number 'N' = The provider number is an NPI number
APP DT	The date the beneficiary was admitted to the hospital (Application date).
REASON CD	Reason Code – Indicates the reason for the injury. Valid values are: 1 = Status inquiry 2 = Inquiry relating to an admission
DATE/TIME	The date and time in Julian YYDDDHHMMSS format.
REQ ID	Requested ID – Identifies person submitting inquiry.
DISP CD	The CWF disposition code assigned to a claim when it is processed through a CWF host site. Valid values include: 01 = Part A inquiry approved; beneficiary has never used Part A services (Type 3 reply). 02 = Part A inquiry approved; beneficiary has had some prior utilization. 03 = Part A inquiry rejected. 04 = Qualified approval; may require further investigation. 05 = Qualified approval; according to CMS's records, this inquiry begins a new benefit period.
TYPE	Identifies the type of CWF reply. Valid value: 3 = Accept
CENT D.O.B	Century of the Beneficiary/patient's date of birth. Valid values are: 8 = 18th Century 9 = 19th Century
D.O.D	Identifies the date of death of the beneficiary/patient.
Part A	
CURR-ENT DT	Current Part A benefits entitlement date (in MMDDYY format).
TERM DT	Termination date for Part A benefits (in MMDDYY format).
PRI-ENT DT	Prior entitlement date for Part A benefits (in MMDDYY format).
TERM DT	Prior termination date for Part A benefits (in MMDDYY format).
Part B	
CURR-ENT	Current Part B benefits entitlement date (in MMDDYY format).
TERM DT	Termination date for Part B benefits (in MMDDYY format).
PRI-ENT DT	Prior entitlement date for Part B benefits (in MMDDYY format).
TERM DT	Prior termination date for Part B benefits (in MMDDYY format).
LIFE: RSRV	Number of lifetime reserve days remaining (00-60).
PSYCH	Number of lifetime psychiatric days available (000-190).
Current Benefit Period Data	
FRST BILL DT	The date of the earliest billing action in the current benefit period (in MMDDYY format).
LST BILL DT	The date of the latest billing action in the current benefit period (in MMDDYY format).
HSP FULL DAYS	The number of regular hospital full days the beneficiary/patient has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary/patient has remaining in the current benefit period.

Field Name	Description
SNF FULL DAYS	The number of SNF full days the beneficiary/patient has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary/patient has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary/patient for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary/patient for the benefit period.
Prior Benefit Period Data	
FRST BILL DT	The date of the earliest billing action in the current benefit period.
LST BILL DT	The date of the latest billing action in the current benefit period.
HSP FULL DAYS	The number of regular hospital full days the beneficiary/patient has remaining in the current benefit period.
HSP PART DAYS	The number of hospital coinsurance days the beneficiary/patient has remaining in the current benefit period.
SNF FULL DAYS	The number of SNF full days the beneficiary/patient has remaining in the current benefit period.
SNF PART DAYS	The number of SNF coinsurance days the beneficiary/patient has remaining in the current benefit period.
INP DED REMAIN	The amount of inpatient deductible remaining to be met by the beneficiary/patient for the benefit period.
BLD DED PNTS	The number of blood deductible pints remaining to be met by the beneficiary/ patient for the benefit period.
Current B	
YR	The most recent Medicare Part B year (in YY format).
CASH	The remaining Part B cash deductible.
BLOOD	The remaining Part B blood deductible pints.
PSYCH	The remaining psychiatric limit.
PT	The physical therapy dollars remaining.
OT	The occupational therapy dollars remaining.
Prior B	
YR	The prior Medicare Part B year (in YY format).
CASH	The Part B cash deductible remaining to be met in the prior year.
BLOOD	The Part B blood deductible pints remaining to be met in the prior year.
PSYCH	The remaining psychiatric limit in the prior year.
PT	Physical therapy dollars remaining in the prior year.
OT	Occupational therapy dollars remaining in the prior year.

Screen 7 (MAP1756) – Field descriptions are provided in the table following Figure 12.

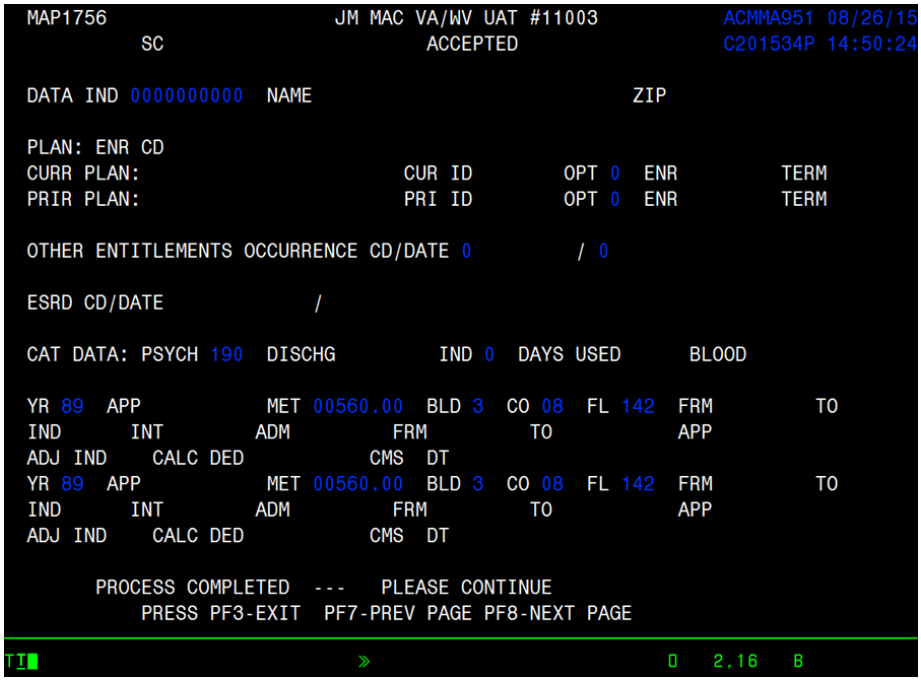


Figure 12 – Beneficiary/CWF Screen 7

Field Name	Description	
DATA IND	Data Indicators – 10-Digit Numeric Field. Valid values are:	
	Pos. 1 – Part B Buy-In	0 = Does not apply 1 = State buy-in involved
	Pos. 2 – Alien indicator	0 = Does not apply 1 = Alien non-payment provision may apply
	Pos. 3 – Psych Pre-Entitlement	0 = Does not apply 1 = Psychiatric pre-entitlement reduction applied
	Pos. 4 – Reason for Entitlement	0 = Normal Entitlement 1 = Disability (DIB) 2 = End Stage Renal Disease (ESRD) 3 = Has or had ESRD, but has current DIB 4 = Old age but had or has ESRD 8 = Has or had ESRD and is covered under premium Part A 9 = Covered under premium Part A
	Pos. 5 – Part A Buy-In	0 = No Part A Buy-In 1 = Part A Buy-In
	Pos. 6 – Rep Payee Indicator	0 = Does not apply 1 = Selected for GEP Contract 2 = Has Rep Payee 3 = Both Conditions Apply
	Pos. 7-10 – Not used at this time	Pre-filled with zeros.
NAME	Displays last name, first name, and middle initial of the beneficiary/patient.	
ZIP	Zip Code of the residence of the beneficiary.	

Field Name	Description
PLAN: ENR CD	Number of periods of Plan enrollment code. Valid values include: 0 = Zero periods of enrollment 1 = One period of enrollment 2 = Two periods of enrollment 3 = More than two periods of enrollment
Current Plan	
CUR ID	Current Plan ID code assigned by CMS. Position — Description 1 — H or 1-9 2 & 3 — State code 4 & 5 — Plan number within the state
OPT	Plan Option Code. Valid values are: **Restricted**— A = Medicare contractor to process all claims. B = Plan to process claims for directly provided services. C = Plan to process all claims. **Unrestricted**— 1 = Medicare contractor to process all Part A and Part B provider claims 2 = Plan to process claims for directly provided services from providers with effective arrangements
ENR	The enrollment date of the Plan benefits (in MMDDYY format).
TERM DT	The termination date of the Plan benefits (in MMDDYY format).
Prior Plan	
PRI ID	Prior Health ID code assigned by CMS: Position — Description 1 — H or 1-9 2 & 3 — State code 4 & 5 — Plan number within the state
OPT	Plan Option Code: **Restricted**— A = Medicare contractor to process all claims. B = Plan to process claims for directly provided services. C = Plan to process all claims. **Unrestricted**— 1 = Medicare contractor to process all Part A and Part B provider claims 2 = Plan to process claims for directly provided services from providers with effective arrangements
ENR	The enrollment date of the Plan benefits for the prior year (in MMDDYY format).
TERM	Termination date of the Plan benefits for the prior year (in MMDDYY format).
OTHER ENTITLEMENTS OCCURRENCE CD/DATE	The first two occurrence codes and dates indicating another Federal Program or another type of insurance that may be the primary payer. Valid occurrence code values include: A = Working Aged beneficiary or spouse covered by Employer Group Health Plan (EGHP) B = End Stage Renal Disease (ESRD) beneficiary in 30-month coordination period and covered by employer health plan C = Medicare has made a conditional payment pending final resolution D = Automobile no-fault or other liability insurance involvement E = Workers' Compensation F = Veteran's Administration program, public health service or other federal agency program G = Working disabled beneficiary or spouse covered by Employer Group Health Plan

Field Name	Description
	H = Black Lung I = Veteran's Administration Program Occurrence Codes — Date Definition 1 or 2: Date is the effective date of applicable program involvement. A - I: Date is the date of previous claim where Medicare was determined to be secondary.
ESRD CD/ DATE	The home dialysis method and effective date in MMDDCCYY format. Valid values are: 1 = Beneficiary elects to receive all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claim. 2 = Beneficiary elects to deal directly with one supplier for home dialysis supplies and equipment and beneficiary submits claim to Carrier.
Cat Data	
PSYCH	The remaining lifetime psychiatric days.
DISCHG	Last or through discharge date (in MMDDYY format).
IND	Identifies whether the discharge date is an interim date. Valid values are: 0 = Initialized 1 = Interim
DAYS USED	The number of pre-entitlement psychiatric days used by the beneficiary/patient.
BLOOD	The number of blood pints carried over from 1988 to 1989.
Days Information (2 occurrences)	
YR	The catastrophic trailer year.
APP	Identifies whether a December inpatient stay has been applied to the current year deductible.
MET	The remaining inpatient hospital deductible.
BLD	The remaining blood deductible.
CO	The remaining skilled nursing facility coinsurance days.
FL	Number of full SNF days remaining.
FRM	The 'From Date' of the earliest processed bill.
TO	The 'Through Date' of the earliest processed bill.
IND	The yearly data indicators: Pos. 1: 0 = Not Used; 2 = Clerical Involvement; 3 = Religious Non-Medical Healthcare Institution/SNF Usage; 4 = Both 1 and 2 Pos. 2: 0 = Not Used; 1 = Through Date is Interim Pos. 3-4: For Future Use
INT	The fiscal Medicare contractor number for earliest processed hospital bill with a deductible.
ADM	The 'Admission Date' for the earliest processed hospital bill with a deductible.
FRM	The 'From Date' for the earliest hospital bill processed with a deductible.
TO	The 'Through Date' for the earliest hospital bill processed with a deductible.
APP	Deductible amount applied for the earliest hospital bill processed with a deductible.
ADJ IND	The type of adjustment made. Valid values are: 0 = No Adjustment 1 = Downward Adjustment 2 = Upward Adjustment
CALC DED	The amount of deductible calculated.
CMS DT	The date the claim was processed by CMS.

Screen 8 (MAP1757) – Field descriptions are provided in the table following Figure 13.

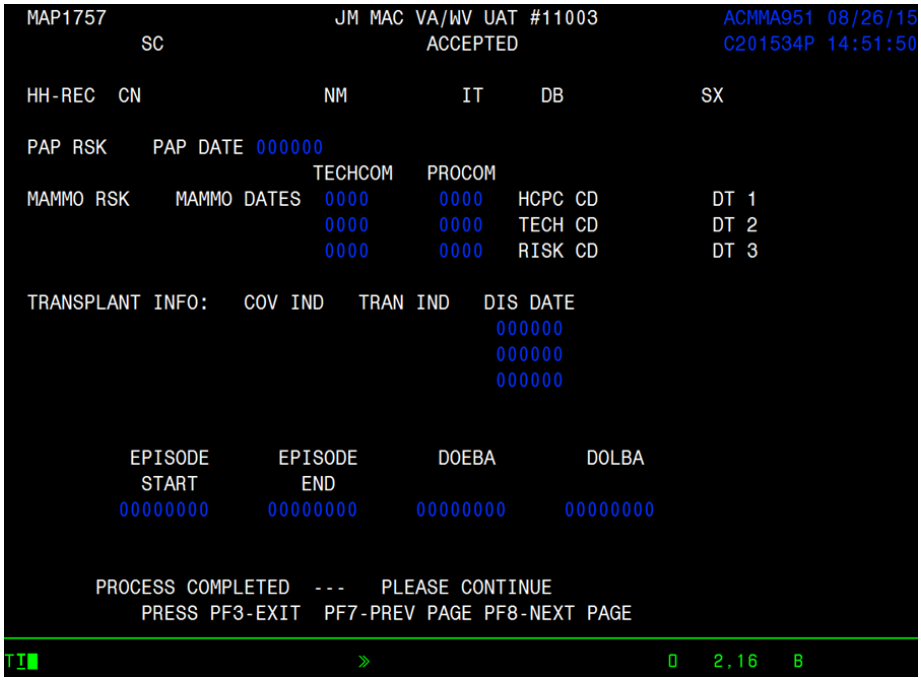


Figure 13 – Beneficiary/CWF Screen 8

Field Name	Description
HH-REC	The requested Home Health record.
CN	Displays the identification number for a claim. If an adjustment or a RTP is being processed, enter the DCN for the claim. If this is a MSP claim leave field blank.
NM	The last name of the beneficiary/ patient.
IT	The first initial of the beneficiary/ patient name.
DB	The date of birth of the beneficiary /patient.
SX	Sex of the beneficiary/patient. Valid values: F = Female M = Male
PAP RSK	PAP Risk Indicator. Valid values are: Y = Yes N = No
PAP DATE	The date of the beneficiary's last PAP Smear.
MAMMO RSK	The mammography risk indicator. Valid values are: Y = Yes N = No
Mammo Dates	
TECHCOM	**Technical Component Date** – The date the technician interpreted the mammography screening. Up to three dates may be displayed in MMYY format.
PROCOM	**Professional Component Date** – The date the mammography screening required an interpretation by a physician. Up to three dates may be displayed in MMYY format.
HCPC CD	The Healthcare Common Procedure Code (HCPC) code.
DT 1	This field identifies the date the HCPC code was returned from CWF. CCYY/MM/DD format.
TECH CD	The technical code.
DT 2	This field identifies the date the TECH code was returned from CWF. CCYY/MM/DD format.
RISK CD	The risk code.
DT 3	This field identifies the date the RISK code was returned from CWF.

Field Name	Description
	CCYY/MM/DD format.
Transplant Info	
COV IND	The Transplant Covered Indicator. Valid values are: Y = Covered Transplant N = Non-covered Transplant
TRAN IND	The type of transplant performed. Valid values are: 1 = Allogeneous Bone Marrow 2 = Autologous Bone Marrow H = Heart Transplant K = Kidney Transplant L = Liver Transplant
DIS DATE	The discharge date for the transplant patient. There may be up to three discharge dates displayed.
HHPPS (Home Health Prospective Payment System)	
EPISODE START	The start date of an episode.
EPISODE END	The end date of an episode.
DOEBA	The first service date of the HHPPS period.
DOLBA	The last service date of the HHPPS period.

Screen 9 (MAP1758) – Field descriptions are provided in the table following Figure 14.

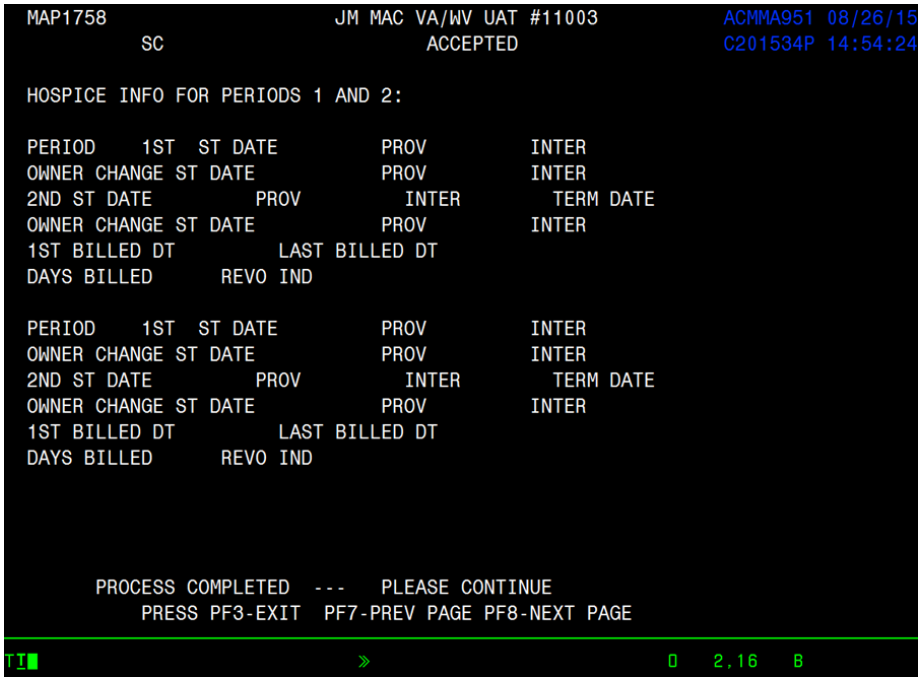


Figure 14 – Beneficiary/CWF Screen 9

Screen 10 (MAP175C) – Field descriptions are provided in the table following Figure 15.

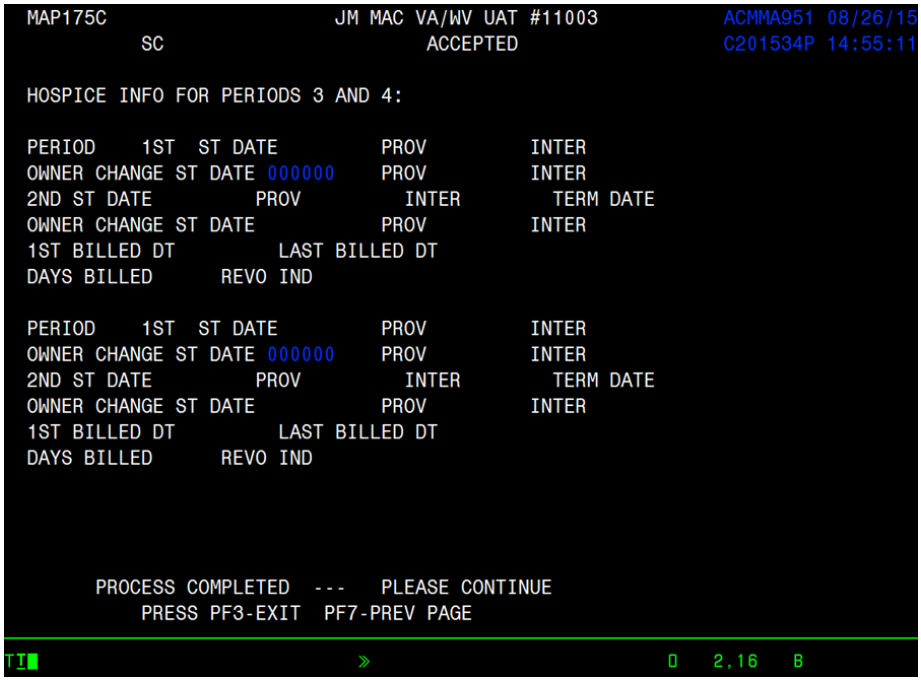


Figure 15 – Beneficiary/CWF Screen 10

Field Name	Description
HOSPICE INFO FOR PERIODS 1 AND 2	There are four occurrences of Hospice Information on two screens to provide for the four most recent hospice periods.
Period 1 (or 3)	
PERIOD	The Hospice Benefit Period Number. Valid values are: 1 = First time a beneficiary uses hospice benefits 2 = Second time a beneficiary uses hospice benefits
1ST START DATE	The beneficiary's effective period with the Hospice Provider (MMDDYY format).
PROV	The hospice's Medicare provider number.
INTER	The hospice's Medicare contractor number.
OWNER CHANGE ST DATE	The start date of a change of ownership for the first Provider, within the election period.
PROV	The number of the Medicare hospice Provider.
INTER	The Medicare contractor number.
2ND START DATE	The date the second benefit period began.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
TERM DATE	The date the hospice benefit period was terminated.
OWNER CHANGE ST DATE	The start date of a change of ownership within the period for the second Provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
1ST BILLED DT	The date of each earliest hospice bill date (in MMDDYY format).
LAST BILLED DT	Each most recent hospice bill date (in MMDDYY format).
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

Field Name	Description
Period 2 (or 4)	
PERIOD	The Hospice Benefit Period Number. Valid values are: 1 = First time a beneficiary uses hospice benefits 2 = Second time a beneficiary uses hospice benefits
1ST START DATE	The beneficiary's effective period with the Hospice Provider (MMDDYY format).
PROV	The hospice's Medicare provider number.
INTER	The hospice's Medicare Contractor number.
OWNER CHANGE ST DATE	The start date of a change of ownership for the first Provider, within the election period.
PROV	The number of the Medicare hospice Provider.
INTER	The hospice's Medicare Contractor number.
2ND START DATE	The date the second benefit period began.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
TERM DATE	The date the hospice benefit period was terminated.
OWNER CHANGE ST DATE	The start date of a change of ownership within the period for the second Provider.
PROV	The second hospice's Medicare provider number.
INTER	The second hospice's Medicare Contractor number.
1ST BILLED DT	The date of each earliest hospice bill date (in MMDDYY format).
LAST BILLED DT	Each most recent hospice bill date (in MMDDYY format).
DAYS BILLED	Number of hospice dates used for each hospice period.
REVO IND	The revocation indicator per hospice period.

Screen 11 (MAP175K) – Field descriptions are provided in the table following Figure 16.

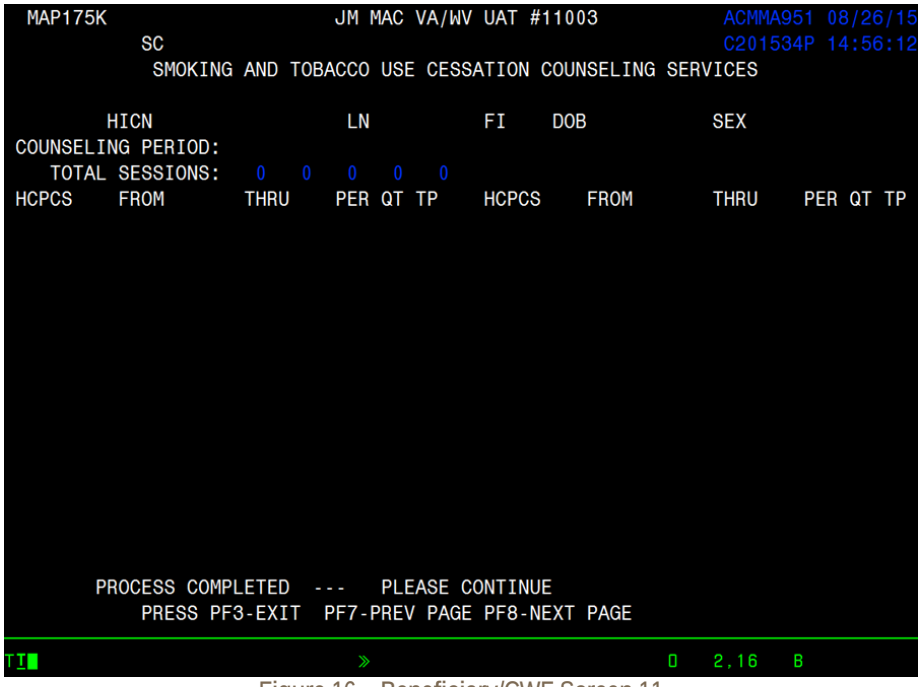


Figure 16 – Beneficiary/CWF Screen 11

Field Name	Description
Smoking and Tobacco Use Cessation Counseling Services	
HICN	The beneficiary's Medicare number as it appears on the Medicare ID card.
LN	The beneficiary's last name.
FI	The first initial of the beneficiary's first name.

Field Name	Description
DOB	The beneficiary's date of birth (in MMDDYY format).
SEX	Valid values are: F = Female M = Male
COUNSELING PERIOD	This field identifies up to five years of counseling data. Valid values are: '1' – One year '2' – Two years '3' – Three years '4' – Four years '5' – Five years
TOTAL SESSIONS	This field identifies the number of sessions billed for the beneficiary. **Note**: If a date range is billed on a detail, and a quantity that matches the range is not identified, CWF posts the session as1 unit. (i.e., 10/25 – 10/27 Unit 1 will post as 1 session.
HCPCS	This field identifies the Healthcare Common Procedure Coding System (HCPCS) code of G0375 or G0376.
FROM	This field displays the 'from' date of the claim in MM/DD/CCYY format.
THRU	This field displays the 'through' date of the claim in MM/DD/CCYY format.
PER	This field identifies up to five year of counseling data. Valid values are: '1' – One year '2' – Two years '3' – Three years '4' – Four years '5' – Five years
QT	**Quantity** - This field identifies the number of services billed for each date.
TP	**Claim Type** – This filed identifies the type of claim. Valid values are: 'O' – Outpatient 'B' – Part B

Screen 12 (MAP175L) – Field descriptions are provided in the table following Figure 17.

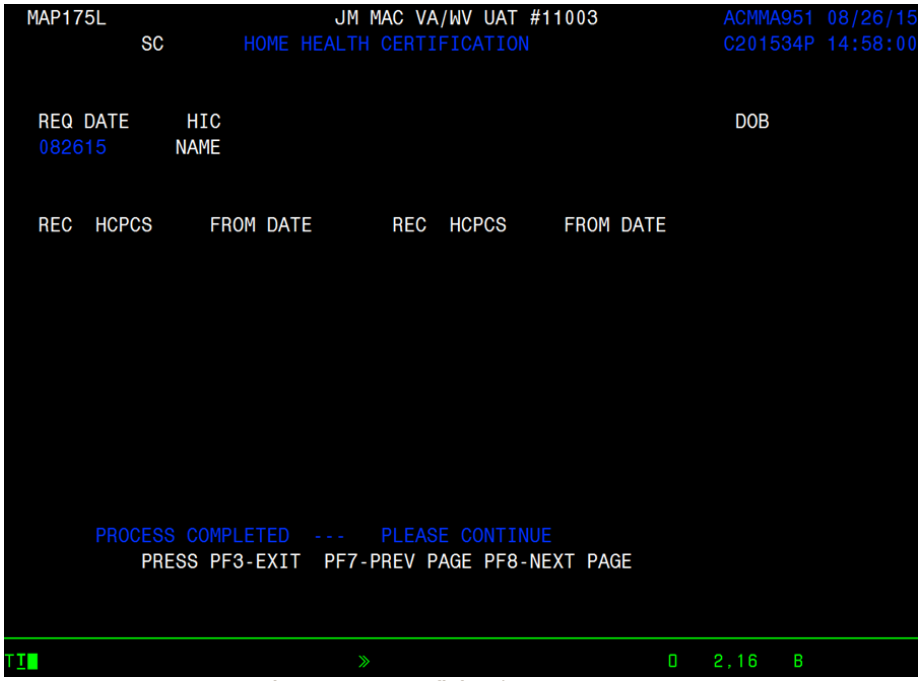


Figure 17 – Beneficiary/CWF Screen 12

Field Name	Description
Home Health Certification	
REQ DATE	Date the request was made through DDE.
HIC	The beneficiary's Medicare number as shown on the Medicare card.
DOB	The beneficiary's date of birth (in MMDDYY format).
NAME	The beneficiary's last and first name.
REC	This field identifies the health insurance record number.
HCPCS	This field identifies the HCPCS code billed.
FROM DATE	This field identifies the home health from date in MMDDYY format.

DRG (Pricer/Grouper)

Select option '11' from the Inquiry Menu to access the DRG/PPS Inquiry screen (MAP1781 & MAP178B). The DRG/PPS Inquiry screen displays detailed payment information calculated by the Pricer and Grouper software programs. Its purpose is to provide specific DRG assignment and PPS payment calculations. It should be used to research PPS information as it pertains to an inpatient stay.

To start the inquiry process, enter the following information:

- Diagnosis code
- Procedure code
- Sex
- Century indicator
- Discharge status
- Date of Discharge
- Provider number
- Review code
- Total charges
- Date of birth **or** age
- Approved length of stay (LOS)
- Covered days
- Number of lifetime reserve days

[TAB] to move between fields on the screen. *Only press* **[ENTER]** *when all fields have been completed.*

DRG/PPS Inquiry Screen

DRG PPS Screen (MAP1781) – Field Descriptors are in the table that follows Figure 18.

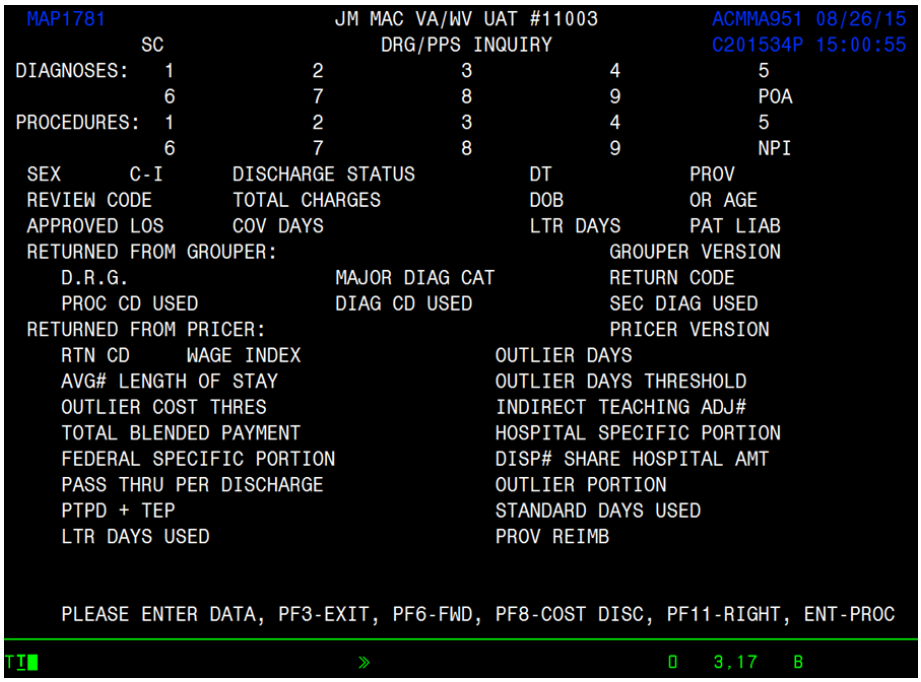


Figure 18 – DRG/PPS Inquiry Screen

Field Name	Description
DIAGNOSES (1 – 9)	Diagnosis Codes – Seven-character alphanumeric fields that identify up to nine codes for coexisting conditions on a particular claim. The *admitting* diagnosis is not entered.
PROCEDURES (1 – 9)	Procedure Codes – Required for inpatient claims. Seven-digit field identifying the principle procedure (first) and up to eight additional procedures.
POA	This field identifies the last character of the Present on Admission (POA) indicator. Valid values are: 'Z' – The end of POA indicators for principal and, if applicable, other diagnoses 'X' – The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' – Not acute care, POA's do not apply
NPI	The provider's National Provider Identifier (NPI) number.
SEX	The Beneficiary's Sex
C-I	Century Indicator – If you enter D.O.B. (date of birth), you must enter the century indicator. Valid values are: 8 =1800-1899 9 =1900-1999 2 = 2000
DISCHARGE STATUS	The Patient's Discharge Status Code. Refer to UB-04 Manual for valid values.
DT	The date the patient was discharged in MMDDYY format.
PROV	The provider's Medicare provider number.
REVIEW CODE	Indicates the code used in calculating the standard payment. Valid values are: 00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers 01 = Pay days outlier – Calculates standard payment and the day outlier portion of the payment if the covered days exceed the outlier cutoff for DRG 02 = Pay cost outlier – Calculates the standard payment and the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold; if the length of stay exceeds the outlier cutoff, no payment is made and a return code of '60' is returned 03 = Pay per diem days – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if the covered days equal or exceed the average length of stay the standard payment is calculated – It also calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers 05 = Pay transfer with cost – Pays transfer with cost outlier approved 06 = Pay transfer no cost – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate any cost outlier portion of the payment 07 = Pay without cost – Calculates the standard payment without cost portion 09 =Pay transfer special DRG post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will calculate the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 11 =Pay transfer special DRG no cost post-acute transfers for DRGs 209, 110,

Field Name	Description
	211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate the cost outlier portion of the payment
TOTAL CHARGES	The total covered charges submitted on the claim.
DOB	The beneficiary's date of birth (MMDDYYYY format).
OR AGE	The beneficiary's age at the time of discharge. This field may be used instead of the date of birth and century indicator.
APPROVED LOS	The approved length of stay (LOS) is necessary for the Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases, to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay.
COV DAYS	The number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary.
LTR DAYS	The number of lifetime reserve days. This 2-digit field may be left blank.
PAT LIAB	The Patient Liability Due identifies the dollar amount owed by the beneficiary to cover any coinsurance days or non-covered days or charges.

After the DRG has been assigned by the system and the PPS payment has been determined, the following information will be displayed on the screen under RETURNED FROM GROUPER or RETURNED FROM PRICER.

Field Name	Description
GROUPER VERSION	The program identification number for the Grouper program used.
D.R.G.	The DRG code assigned by the CMS grouper program using specific data from the claim, such as length of stay, covered days, sex, age, diagnosis and procedure codes, discharge data and total charges.
MAJOR DIAG CAT	Identifies the category in which the DRG resides. Valid values are: 01 = Diseases and Disorders of the Nervous System 02 = Diseases and Disorders of the Eye 03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat 04 = Diseases and Disorders of the Respiratory System 05 = Diseases and Disorders of the Circulatory System 06 = Diseases and Disorders of the Digestive System 07 = Diseases and Disorders of the Hepatobiliary System and Pancreas 08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue 09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast 10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders 11 = Diseases and Disorders of the Kidney and Urinary Tract 12 = Diseases and Disorders of the Male Reproductive System 13 = Diseases and Disorders of the Female Reproductive System 14 = Pregnancy, Childbirth, and the Puerperium 15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period 16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders

Field Name	Description
	17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms 18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites) 19 = Mental Diseases and Disorders 20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders 21 = Injuries, Poisonings, and Toxic Effects of Drugs 22 = Burns 23 = Factors Influencing Health Status and Other Contacts with Health Services 24 = Multiple Significant Trauma 25 = Human Immunodeficiency Viral Infections
RETURN CODE	The Return Code reflects the status of the claim when it has returned from the Grouper Program. This is a one-digit alphanumeric field.
PROC CD USED	Procedure code(s) that identify the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims.
DIAG CD USED	Identifies the primary diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	Diagnosis code used by the Grouper program for calculation.
Returned From Pricer	
PRICER VERSION	The program version number for the Pricer program used.
RTN CD	A Return Code that identifies the status of the claim when it has returned from the Pricer program.
WAGE INDEX	Provider's wage index factor for the state where the services were provided to determine reimbursement rates for the services rendered.
OUTLIER DAYS	The number of outlier days that exceed the cutoff point for the applicable DRG.
AVG # LENGTH OF STAY	The predetermined average length of stay for the assigned DRG.
OUTLIER DAYS THRESHOLD	Shows the number of days of utilization permissible for this claim's DRG code. Day outlier payment is made when the length of stay (including days for a beneficiary awaiting SNF placement) exceeds the length of stay for a specific DRG plus the CMS-mandated adjustment calculation.
OUTLIER COST THRES	Additional payment amount for claims with extraordinarily high charges. Payment is based on the applicable Federal rate percentage times 75% of the difference between the hospital's cost for the discharge and the threshold established for the DRG.
INDIRECT TEACHING ADJ#	The amount of adjustment calculated by the Pricer for teaching hospitals.
TOTAL BLENDED PAYMENT	The total PPS payment amount consisting of the Federal, hospital, outlier and indirect teaching reductions (such as Gramm Rudman) or additions (such as interest).
HOSPITAL SPECIFIC PORTION	The hospital portion of the total blended payment.
FEDERAL SPECIFIC PORTION	The Federal portion of the total blended payment.
DISP# SHARE HOSPITAL AMT	The percentage of a hospital total Medicare Part A patient days attributable to Medicare patients who are also SSI.
PASS THRU PER DISCHARGE	Identifies the pass through discharge cost.
OUTLIER PORTION	The dollar amount calculated that reflects the outlier portion of the charges.
PTPD + TEP	The sum of the pass through per discharge cost plus the total blended payment amount.
STANDARD DAYS USED	The number of regular Medicare Part A days covered for this claim.
LTR DAYS USED	The number of lifetime Reserve Days used during this benefit period.

Field Name	Description
PROV REIM	The actual payment amount to the provider for this claim. This will be the amount on the Remittance Advice/Voucher.

DRG PPS Screen (MAP178B) – Field Descriptors are in the table that follows Figure 19.

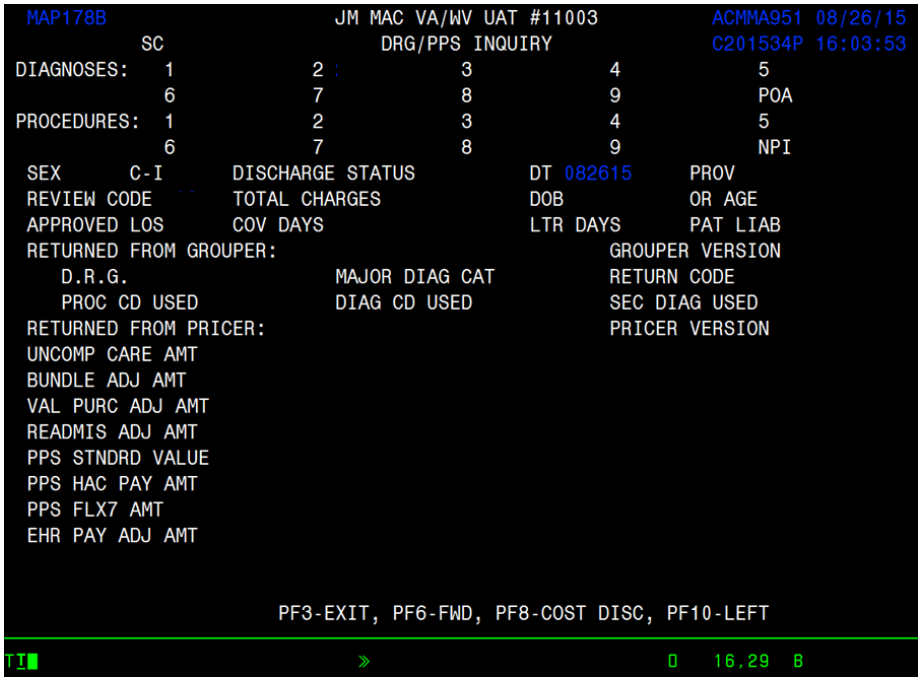


Figure 19 – DRG/PPS Inquiry Screen

The following fields on this screen will remain the same as the data that was entered on MAP1781 in Figure 18.

Field Name	Description
DIAGNOSES (1 – 9)	Diagnosis Codes – Seven-character alphanumeric fields that identify up to nine codes for coexisting conditions on a particular claim. The *admitting* diagnosis is not entered.
PROCEDURES (1 – 9)	Procedure Codes – Required for inpatient claims. Seven-digit field identifying the principle procedure (first) and up to eight additional procedures.
POA	This field identifies the last character of the Present on Admission (POA) indicator. Valid values are: 'Z' – The end of POA indicators for principal and, if applicable, other diagnoses 'X' – The end of POA indicators for principal and, if applicable, other diagnoses in special processing situations that may be identified by CMS in the future. ' ' – Not acute care, POA's do not apply
NPI	The provider's National Provider Identifier (NPI) number.
SEX	The Beneficiary's Sex
C-I	Century Indicator – If you enter D.O.B. (date of birth), you must enter the century indicator. Valid values are: 8 =1800-1899 9 =1900-1999 2 = 2000
DISCHARGE STATUS	The Patient's Discharge Status Code. Refer to UB-04 Manual for valid values.
DT	The date the patient was discharged in MMDDYY format.
PROV	The provider's Medicare provider number.

Field Name	Description
REVIEW CODE	Indicates the code used in calculating the standard payment. Valid values are: 00 = Pay with outlier – Calculates standard payment and attempts to pay only cost outliers 01 = Pay days outlier – Calculates standard payment and the day outlier portion of the payment if the covered days exceed the outlier cutoff for DRG 02 = Pay cost outlier – Calculates the standard payment and the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold; if the length of stay exceeds the outlier cutoff, no payment is made and a return code of '60' is returned 03 = Pay per diem days – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if the covered days equal or exceed the average length of stay the standard payment is calculated – It also calculates the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 04 = Pay average stay only – Calculates the standard payment, but does not test for days or cost outliers 05 = Pay transfer with cost – Pays transfer with cost outlier approved 06 = Pay transfer no cost – Calculates a per diem payment based on the standard payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate any cost outlier portion of the payment 07 = Pay without cost – Calculates the standard payment without cost portion 09 =Pay transfer special DRG post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will calculate the cost outlier portion of the payment if the adjusted charges on the bill exceed the cost threshold 11 =Pay transfer special DRG no cost post-acute transfers for DRGs 209, 110, 211, 014, 113, 236, 263, 264, 429, 483 – Calculates a per diem payment based on the standard DRG payment if the covered days are less than the average length of stay for the DRG; if covered days equal or exceed the average length of stay, the standard payment is calculated – It will not calculate the cost outlier portion of the payment
TOTAL CHARGES	The total covered charges submitted on the claim.
DOB	The beneficiary's date of birth (MMDDYYYY format).
OR AGE	The beneficiary's age at the time of discharge. This field may be used instead of the date of birth and century indicator.
APPROVED LOS	The approved length of stay (LOS) is necessary for the Pricer to determine whether day outlier status is applicable in non-transfer cases, and in transfer cases, to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted or when entitlement begins during the stay, Pricer length of stay days may exceed Pricer covered days in the non-outlier portion of the stay.
COV DAYS	The number of Medicare Part A days covered for this claim. Pricer uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, Pricer may not return the correct utilization days. The CWF host system determines and/or validates the correct utilization days to charge the beneficiary.
LTR DAYS	The number of lifetime reserve days. This 2-digit field may be left blank.

Field Name	Description
PAT LIAB	The Patient Liability Due identifies the dollar amount owed by the beneficiary to cover any coinsurance days or non-covered days or charges.

The information displayed under the RETURNED FROM GROUPER on this screen will be the same as the data returned after the DRG was calculated on MAP1781 in Figure 18.

Field Name	Description
GROUPER VERSION	The program identification number for the Grouper program used.
D.R.G.	The DRG code assigned by the CMS grouper program using specific data from the claim, such as length of stay, covered days, sex, age, diagnosis and procedure codes, discharge data and total charges.
MAJOR DIAG CAT	Identifies the category in which the DRG resides. Valid values are: 01 = Diseases and Disorders of the Nervous System 02 = Diseases and Disorders of the Eye 03 = Diseases and Disorders of the Ear, Nose, Mouth and Throat 04 = Diseases and Disorders of the Respiratory System 05 = Diseases and Disorders of the Circulatory System 06 = Diseases and Disorders of the Digestive System 07 = Diseases and Disorders of the Hepatobiliary System and Pancreas 08 = Diseases and Disorders of the Musculoskeletal System and Connective Tissue 09 = Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast 10 = Endocrine, Nutritional, and Metabolic Diseases and Disorders 11 = Diseases and Disorders of the Kidney and Urinary Tract 12 = Diseases and Disorders of the Male Reproductive System 13 = Diseases and Disorders of the Female Reproductive System 14 = Pregnancy, Childbirth, and the Puerperium 15 = Newborns and Other Neonates with Conditions Originating in the Prenatal Period 16 = Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders 17 = Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms 18 = Infectious and Parasitic Diseases (Systemic or Unspecified Sites) 19 = Mental Diseases and Disorders 20 = Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders 21 = Injuries, Poisonings, and Toxic Effects of Drugs 22 = Burns 23 = Factors Influencing Health Status and Other Contacts with Health Services 24 = Multiple Significant Trauma 25 = Human Immunodeficiency Viral Infections
RETURN CODE	The Return Code reflects the status of the claim when it has returned from the Grouper Program. This is a one-digit alphanumeric field.
PROC CD USED	Procedure code(s) that identifies the principal procedure(s) performed during the billing period covered by the claim. Required for inpatient claims.
DIAG CD USED	Identifies the primary diagnosis code used by the Grouper program for calculation.
SEC DIAG USED	Diagnosis code used by the Grouper program for calculation.

The Returned from Pricer data displayed on this screen will be as follows:

Field Name	Description
GROUPER VERSION	The program identification number for the Grouper program used.
PRICER VERSION	The program version number for the Pricer program used.

Field Name	Description
UNCOMP CARE AMT	**Uncompensated Care Payment Amount**: This is the amount published by CMS to the MACs (by provider) entitled to an uncompensated care payment amount add on. The MACs enter the amount for each Federal Fiscal year begin date, 10/01, based on published information. This is an eleven-digit field in 9999999.99 format.
BUNDLE ADJ AMT	This field identifies the adjustment amount for hospitals participating in the Bundled Payments for Care Improvement Initiative (BPCI), Model 1 (demo code 61). This is an eleven-digit field in 9999999.99 format.
VAL PURC ADJ AMT	This field identifies the adjustment amount for hospitals participating in the Value Based Purchase Program. This is an eleven-digit field in 9999999.99 format.
READMIS ADJ AMT	This field identifies the reduction adjustment for those hospitals participating in the Hospital Readmissions Reduction program. This is an eleven-digit field in 9999999.99 format.
PPS STNDRD VALUE	This field identifies the final standardized amount. This value is returned from the IPPS Pricer for claims that meet the criteria identified in specification S0580000. This is an eleven-digit field in 9999999.99- format.
PPS HAC PAY AMT	This field identifies the Hospital Acquired Condition (HAC) payment reduction amount. This is an eleven-digit field in 9999999.99 format.
PPS FLX7 AMT	This field is reserved for future use. This is an eleven-digit field in 9999999.99 format.
EHR PAY ADJ AMT	This field identifies the reduction adjustment amount for hospitals not meaningful users of EHR. This is an eleven-digit field in 9999999.99 format.

DRG Cost Disclosure Inquiry (MAP1782) - Field descriptions are provided in the table following Figure 20.

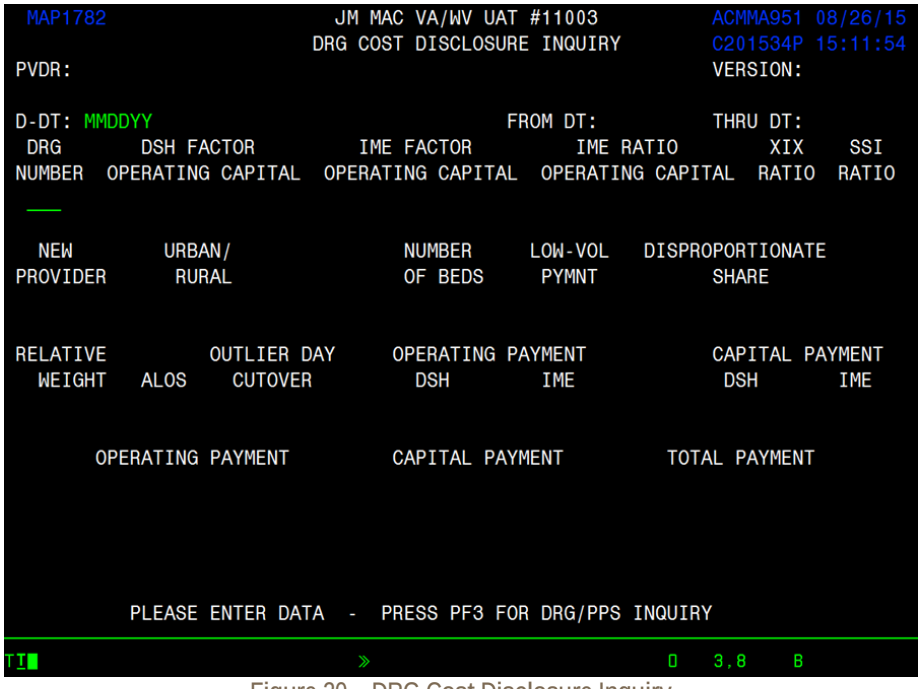


Figure 20 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	Contains the provider name
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The From Date (MMDDYY Format)
THRU DT	The Thru Date (MMDDYY Format)

Field Name	Description
DRG NUMBER	Pricer version number (five-position alphanumeric field)
DSH FACTOR OPERATING CAPITAL	Operating disproportionate share factor (five-digit field in 9.9999 format)
IME FACTOR OPERATING CAPITAL	Operating indirect medical education factor (five-digit field in 9.9999 format)
IME RATIO OPERATING CAPITAL	Operating indirect medical education ratio (five-digit field in 9.9999 format)
XIX RATIO	XIX ratio (five-digit field in 9.9999 format)
SSI RATIO	Supplemental security income ratio, which determines if the hospital qualifies for a disproportionate share adjustment (five-digit field in 9.999 format)
NEW PROVIDER	Displays whether or not the provider is a New Provider.
URBAN/RURAL	The type and location of the hospital and is determined by the DRG pricer (eleven-digit alphanumeric field). Valid values are: Large Urban Other Urban Rural
NUMBER OF BEDS	The number of beds in the facility (six-digit field in 999999 format)
LOW-VOL PYMNT	Amount calculated by the inpatient prospective payment systems (IPPS) Pricer is an estimated interim payment. This estimated interim low-volume payment amount will be adjusted at cost report settlement, if any of the payment amounts upon which the low-volume payment amount is based are recalculated at cost report settlement (for example payments for disproportionate share hospital (DSH), indirect medical education (IME), or federal rate versus hospital-specific rate payments for sole community hospitals/Medicare dependent hospitals).
DISPROPORTIONATE SHARE	The disproportionate share amount (five-digit field in 9.9999 format)
RELATIVE WEIGHT	The relative weight amount (six-digit field in 99.9999 format)
ALOS	**Average length of stay** – Identifies the CMS-predetermined LOS based on certain claim data (three-digit field in 99.9 format)
OUTLIER DAY CUTOVER	**Outlier day cutover –** Identifies the outlier day cutover amount (three-digit field in 99.9 format)
OPERATING DSH	**Operating payment disproportionate share –** Identifies the operating payment disproportionate share amount (eight-digit field in $999,999.99 format)
PAYMENT IME	**Operating payment indirect medical education –** Identifies the operating payment indirect medical education amount (eight-digit field in $999,999.99 format)
CAPITAL DSH	**Capital payment disproportionate share** – Identifies the capital payment disproportionate share amount (eight-digit field in $999,999.99 format)
PAYMENT IME	**Capital payment indirect medical education** – Identifies the capital payment indirect medical education amount (eight-digit field in $999,999.99 format)
OPERATING PAYMENT	**Operating payment –** Identifies the total amount for operating payments (eight-digit field in $999,999.99 format)
CAPITAL PAYMENT	**Capital payment** – Identifies the total amount for capital payments (eight-digit field in $999,999.99 format)
TOTAL PAYMENT	**Total Payment –** Identifies the total amount of payments (eight-digit field in $999,999.99 format)

DRG Cost Disclosure Inquiry (MAP1783) Field descriptions are provided in the table following Figure 21.

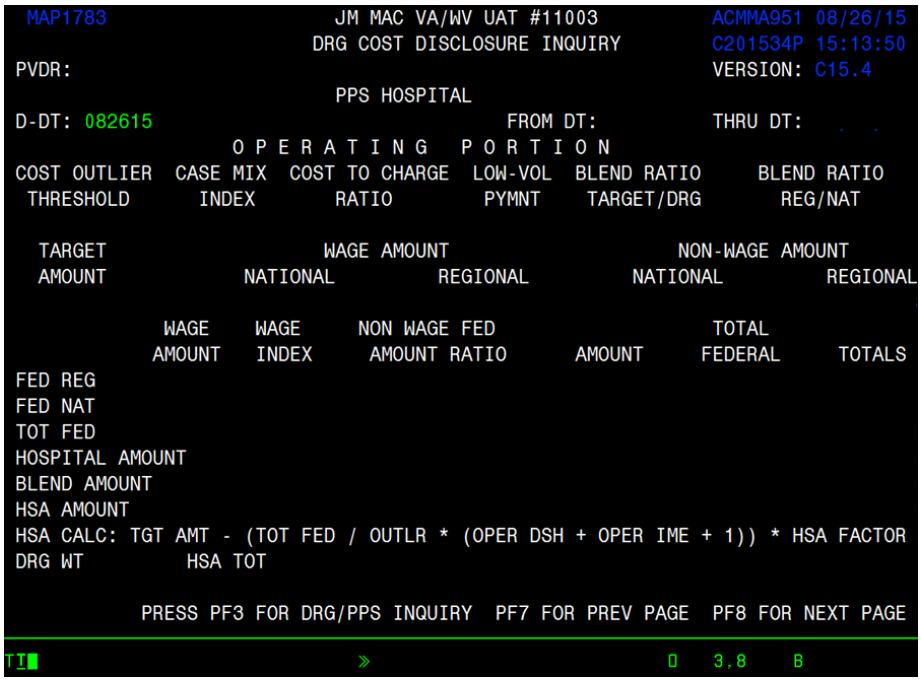


Figure 21 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	This field identifies the program version number for the Pricer program used.
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The beginning date of service (MMDDYY Format)
THRU DT	The ending date of service (MMDDYY Format)
Operating Portion	
COST OUTLIER THRESHOLD	This field identifies the cost outlier threshold amount, which is the standard operating threshold for computing cost outlier payments.
CASE MIX INDES	This field identifies the case mix index from the operating PPS base year.
COST TO CHARGE RATIO	This field identifies the Cost to Charge ratio of operating cost to charges.
LO-VOL PYMNT	This field identifies the low-volume payment amount calculated by the IPPS Pricer.
BLEND REATIO TARGET/DRG	These fields identify the ratio target amount and federal amount used during operating PPS transition periods.
BLEND RATIO REG/NAT	These fields identify the ratio of the regional amount and national amount use during the operating PPS transition periods to determine the operating federal rate.
TARGET AMOUNT	This field identifies the Target amount (the updated hospital specific rate). NOTE: This is used to determine Health Service Area (HSA) add-on amounts for sole community and Medicare dependents hospitals.
WAGE AMOUNT NATIONAL	This field identifies the national wage-related rate. It is used to determine the labor portion of the operating federal rate.
WAGE AMOUNT REGIONAL	This field identifies the regional wage-related amount.
NON-WAGE AMOUNT NATIONAL	This field identifies the national non-wage-related rate. It is used to determine the labor portion of the operating federal rate.

Field Name	Description
NON-WAGE AMOUNT REGIONAL	This field identifies the regional non-wage-related amount.
WAGE AMOUNT	This field identifies the wage-related amount.
WAGE INDEX	This field identifies the wage index as supplied by CMS to be used for the state in which the services were provided to determine reimbursement rates for the services rendered.
NON WAGE FED AMOUNT RATIO	This field identifies the Non-Wage Federal Amount Ratio.
AMOUNT	This field identifies the total amount.
TOTAL FEDERAL	This field identifies the total Federal amount.
TOTALS	This field identifies the total.
FED REG	**Federal Regional** – This field identifies the amount for columns: Wage Amount, Wage Index, Non-Wage Federal Amount Ratio, and Amount.
FED NAT	**Federal National** – This field identifies the amount for columns: Wage Amount, Wage Index, Non-Wage Federal Amount Ratio, and amount.
TOT FED	**Total Federal** – This field identifies amounts for columns Total Federal and Totals. Refer to the note for corresponding formats.
HOSPITAL AMOUNT	This field identifies amounts for columns: Amount and Totals.
BLEND AMOUNT	This field identifies amounts for columns: Wage Index, Non-Wage Federal Amount Ratio, Amount, and Totals.
HSA AMOUNT	This field identifies amounts for columns: Wage Index, Non-Wage Amount, Federal Amount Ratio, Amount, and Totals.
HAS CALC: TGT AMT – (TOT FED / OUTLR * (OPER DSH + OPER IME + 1)) * HAS FACTOR	**Health Service Area (HSA) Calculation** - This field identifies the calculation for HSA.
DRG WT	**Diagnosis Related Group Weight** – This field identifies the payment weight of the DRG.
HAS TOT	**HSA Total** – This field identifies the total of the HSA amount multiplied by the DRG Weight.

DRG Cost Disclosure Inquiry (MAP1784) Field descriptions are provided in the table following Figure 22.

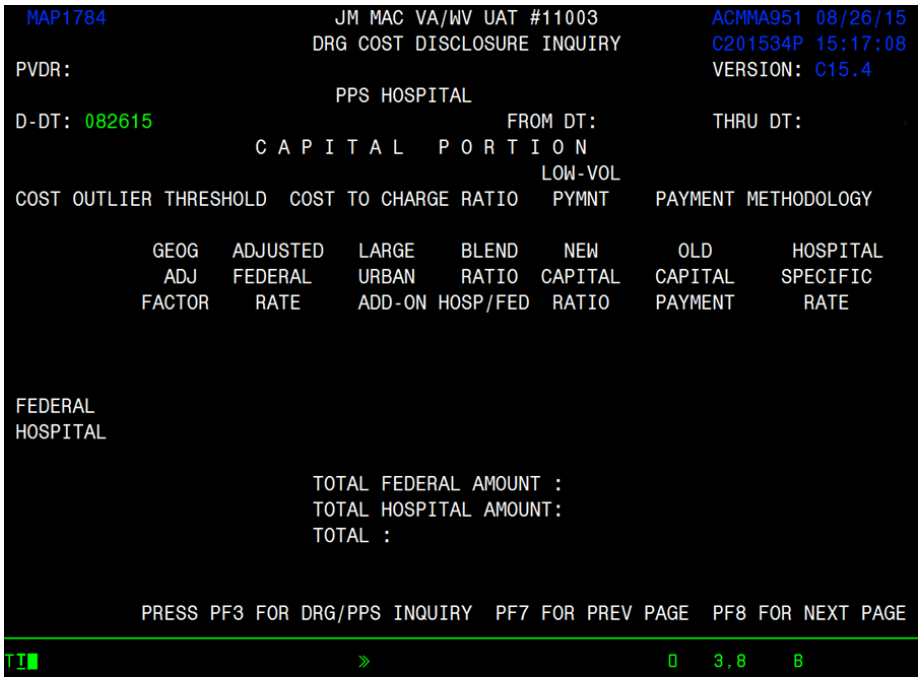


Figure 22 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	This field identifies the program version number for the Pricer program used.
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The beginning date of service (MMDDYY Format)
THRU DT	The ending date of service (MMDDYY Format)
Capital Portion	
COST OUTLIER THRESHOLD	This field identifies the cost outlier threshold amount, which is the standard operating threshold for computing cost outlier payments.
COST TO CHARGE RATIO	This field identifies the Cost to Charge ratio of operating cost to charges.
LOW-VOL PYMT	This field identifies the low-volume payment amount calculated by the IPPS Pricer.
PAYMENT METHOLODOGY	This field identifies the capital PPS payment methodology.
GEOG ADJ FACTOR	**Geographical Adjustment Factor** – This field identifies factor used to adjust the capital federal rate, based on the applicable wage index.
ADJUSTED FEDERAL RATE	This field identifies the base capital rate.
LARGE URBAN ADD-ON	This field identifies the federal rate applicable to those hospitals located in a 'large urban' SMSA.
BLEND RATIO HOSP/FED	These fields identify the ratio of the Hospital Specific Rate (HSR) and the federal rate used to compute capital payments under PPS.
NEW CAPITAL RATIO	This field identifies new capital to total capital and is applicable for hospitals being reimbursed under the hold harmless payment method for capital.
OLD CAPITAL PAYMENT	This field identifies the old capital cost per discharge as provided by the hospital or as provided by the latest filed cost report under capital PPS and is applicable for those hospitals being reimbursed under the hold harmless payment method for capital.

Field Name	Description
HOSPITAL SPECIFIC RATE	This field identifies the capital base period cost per discharge updated to applicable fiscal year-end.
Federal Hospital	
TOTAL FEDERAL AMOUNT	This field identifies the Total Federal amount.
TOTAL HOSPITAL AMOUNT	This field identifies the Total Hospital amount.
TOTAL	This field identifies the total Federal and Hospital amounts.

DRG Cost Disclosure Inquiry (MAP1785) Field descriptions are provided in the table following Figure 23.

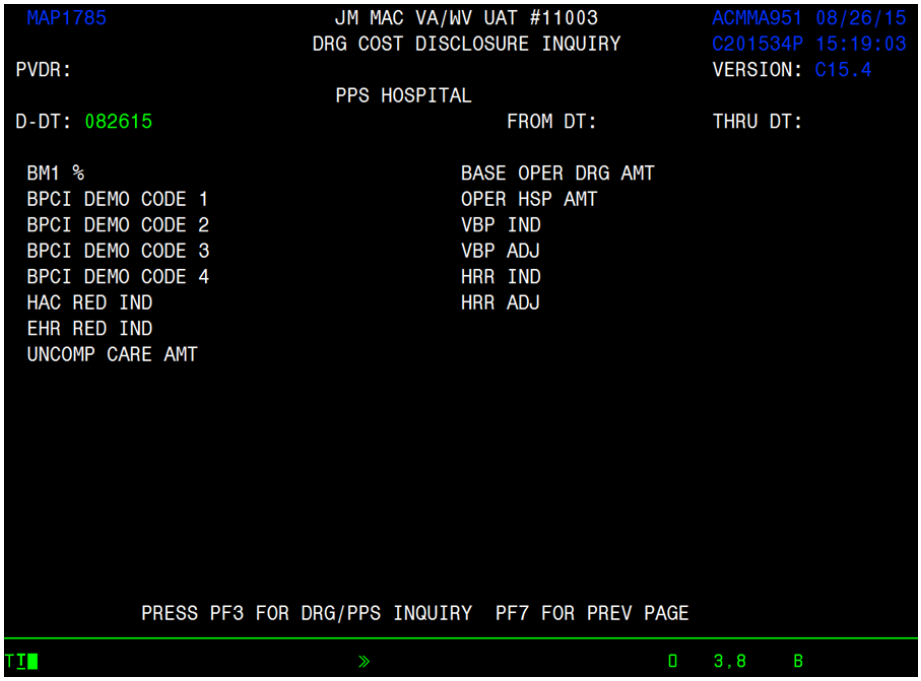


Figure 23 – DRG Cost Disclosure Inquiry

Field Name	Description
PVDR	Displays the provider number
VERSION	This field identifies the program version number for the Pricer program used.
D-DT	The date for which the DRG information is being selected (MMDDYY Format)
FROM DT	The beginning date of service (MMDDYY Format)
THRU DT	The ending date of service (MMDDYY Format)
BM1%	This field identifies the Bundle Model 1 Discount Percentage. This is a two-position alphanumeric field in .99 format.
BASE OPER DRG AMT	This field identifies the Base Operating DRG Payment Amount. This is the amount a hospital would normally receive for the discharge of a Medicare patient.
BPCI DEMO Code 1	This field identifies the Bundled Payment for Care Improvement Indicator. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
OPER HSP AMT	**Operating HSP Amount** – This field identifies the Operating HSP (Hospital Specific Payment) DRG amount.

Field Name	Description
BPCI DEMO CODE 2	This field identifies the Bundled Payment for Care Improvement Indicator 2. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
VBP IND	This field identifies the Value Based Pricing Indicator. This is a one-position alphanumeric field, and the valid values are 'Y' or 'N'.
BPCI DEMO CODE 3	This field identifies the Bundled Payment for Care Improvement Indicator 3. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
VBP ADJ	This field identifies the Value Based Pricing Adjustment.
BPCI DEMO 4	This field identifies the Bundled Payment for Care Improvement Indicator 4. This is a two-digit field, and the valid values are: '61' = Bundled Payments for Care Model 1 '62' = Bundled Payments for Care Model 2 '63' = Bundled Payments for Care Model 3 '64' = Bundled Payments for Care Model 4
HRR IND	This field identifies the Hospital Readmission Reduction (HRR) Program Indicator. This is a one-position alphanumeric field, and the valid values are '0' through '9'.
HAC RED IND	This field is reserved for future use. This is a one-position alphanumeric field. The valid values for IPPS are: Blank = Hospital Acquired Condition Reduction Program – Non PPS N = Hospital Acquired Condition Reduction Program - PPS
HRR ADJ	**Hospital Readmission (HPR)** Adjustment: This field identifies the HRR adjustment. This is a six-digit field in 9.9999 format.
HER RED IND	**Electronic Health Record Adjustment Reduction Indicator**: This field identifies the HER adjustment reduction indicator for providers that are subject to claim adjustments when the provider does not meet the guidelines for use of EHR technology. This is a one-position alphanumeric field. Valid values are: ▪ Y = Reduction applies ▪ Blank = Reduction does not apply
UNCOMP CARE AMT	**Uncompensated Care Payment Amount**: This is the amount published by CMS to the MACs (by provider) entitled to an uncompensated care payment amount add on. The MACs enter the amount for each Federal Fiscal year begin date, 10/01, based on published information. This is a ten-digit field in 9999999.99 format.

Claims Summary Inquiry

Select option '12' from the Inquiry Menu to access the Claims Summary Inquiry screen (MAP1741). The Claims Summary Inquiry screen displays specific claim history information for *all* **pending** (RTP claims, MSP claims, Medical Review claims) and **processed** (paid, rejected, denied) claims. The claim status information is available on-line for viewing immediately after the claim is updated/entered on DDE. The entire claim (six pages) can be viewed on-line through the claim inquiry function **but it cannot be updated from this screen.**

Common status and location codes (S/LOC) (see Section 1 for more information) are listed in the following table.

Code	Description
P B9996	Payment Floor.
P B9997	Paid/Processed Claim.

Code	Description
P B7501	Post-Pay Review.
P B7505	Post-Pay Review.
R B9997	Claims Processing Rejection.
D B9997	Medical Review Denial.
T B9900	Daily Return to Provider (RTP) Claim – Not yet accessible.
T B9997	RTP Claim – Claim may be accessed and corrected through the Claim and Attachments Corrections Menu (Main Menu Option 03).
S B0100	Beginning of the FISS batch process.
S B6000	Claims awaiting the creation of an Additional Development Request (ADR) letter. [Do not press [F9] on these claims because the FISS will generate another ADR.]
S B6001	Claims awaiting a provider response to an ADR letter.
S B9000	Claims ready to go to a Common Working File (CWF) Host Site.
S B9099	Claims awaiting a response from a CWF Host Site.
S M0nnn	Suspended claims/adjustments requiring Palmetto GBA staff intervention (the 'n' denotes a variety of FISS location codes).

Performing Claims Inquiries

1. To start the inquiry process, enter the beneficiary's Medicare number, or leave out the beneficiary's Medicare number and enter any of the following fields:
   - Type of bill (TOB)
   - S/LOC
   - Type an '**S**' in the first position of the S/LOC field to view all the suspended claims
   - Type a '**P**' in the first position of the S/LOC field to view all the paid/processed claims
   - Type a '**T**' in the first position of the S/LOC field to view claims returned for correction
   - Type an '**R**' in the first position of the S/LOC field to view all the rejected claims.
   - From Date (optional field – enter a date if you only want to view claims within a certain date range)
   - To Date (optional field – enter a date only if you want to view claims within a certain date range)
2. Once the appropriate claim history displays, type an '**S**' in the SEL field in front of the claim you wish to view.
3. Press **[ENTER]** to display the DDE electronic claim. Refer to Section 5 – Claim Entry for illustrations of the UB-04 claim screens and field descriptions.

   Note: You may only select one claim at the time.

Viewing an Additional Development Request (ADR) Letter

An ADR is an additional development request for medical records. Palmetto GBA's medical review department uses ADR's to request medical records from providers during the medical review process. Do the following to view an ADR letter for claims in the ADR status/location:

1. Type '**S B6**' in the S/LOC field.
2. Press **[ENTER]** and all claims in an S B6000 or S B6001 status/location will display.
3. Type an '**S**' in the SEL field of the desired claim and press **[ENTER]**.
4. The ADR letter immediately follows claim page 6 (MAP1716). The ADR will consist of 2 pages.
   Note: Do not use the [F9] function key with these claims. If you press [F9], the FISS will generate a new ADR.

Claim Summary Inquiry screen (MAP1741) – Field descriptions are provided in the table following Figure 24.

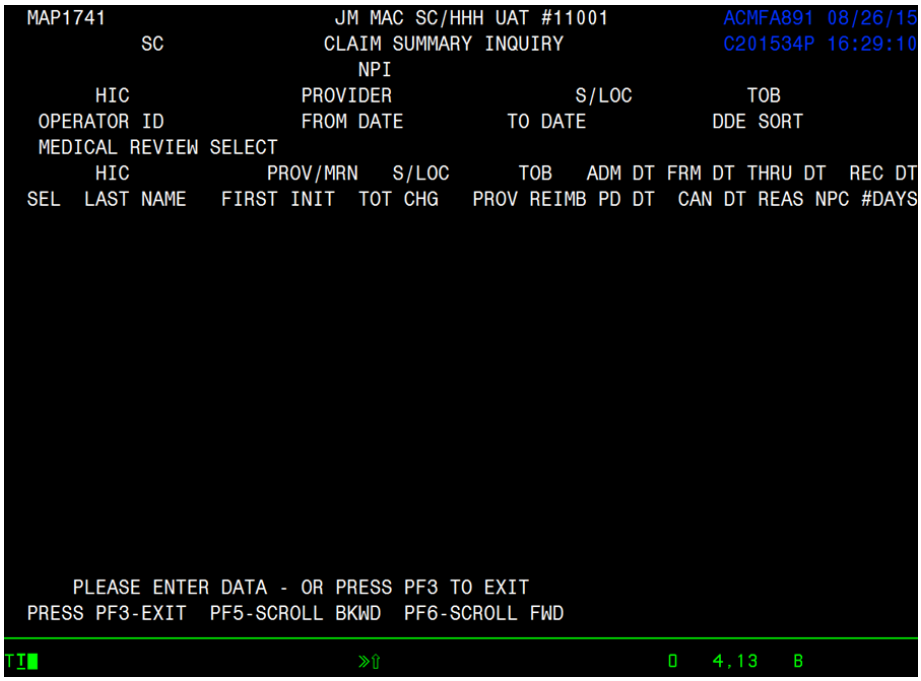


Figure 24 – Claim Summary Inquiry Screen

Field Name	Description
NPI	This field identifies the National Provider Identifier number.
HIC	Type the health insurance claim number to view a particular beneficiary's claims data.
PROVIDER	Your Medicare ID number will automatically display. **Note:** If your facility has sub-units/aliases (e.g., SNF, ESRD, CORF, ORF) the provider number of the sub-unit must be typed in this field. If the correct provider number associated with the claim you wish to view is not entered, an error message PROCESS COMPLETE --- NO MORE DATA THIS TYPE will be received.
S/LOC	Status and location allows you to type a particular status and location you want to view. See Section 1 for more information regarding status and location codes.
TOB	Type of bill allows you to enter a particular type of bill you want to view. The TOB field consists of 3 digits. The first position indicates the type of facility. The second indicates the type of care. The third position indicates the bill frequency. The first two positions are required for a search.
OPERATOR ID	Operator ID is automatically displayed and indicates the individual who accessed the screen.
FROM DATE	Type the 'From Date' of service you want to view (in MMDDYY format).
TO DATE	Type the 'To Date' of service you want to view (in MMDDYY format).
DDE SORT	This field allows the listed claims to be sorted according to specific criteria. Note: This is only accessible in Claims Correction mode.
MEDICAL REVIEW SELECT	This field is used to narrow the claim selection for inquiry. This provides the ability to view only claims pending or returned for medical review. Note: This field is only accessible in Claims Correction mode.
SEL	This field is used to select a claim to view or update. Tab down to the claim and enter an 'S' to view or a 'U' to update. Note: When this screen appears, this field is blank.
First Line Of Data	
HIC	Patient's health insurance claim number as it was originally typed.

Field Name	Description
PROV/MRN	Medicare provider number/Medical Record Number assigned to the facility by CMS. MRN-USED IN Claims Correction mode.
S/LOC	The status/location code assigned to the claim by the FISS.
TOB	The type of facility, bill classification and frequency of the claim in a particular period of care.
ADM DT	The admission date on the claim.
FRM DT	The 'From Date' on the claim.
THRU DT	The 'Through Date' on the claim.
REC DT	The date the claim was received in the FISS.
Second Line Of Data	
SEL	Type an '**S**' under this field to the left of a specific claim to select that claim. Press [ENTER] to display 'detailed' claim information for the claim you selected. See the Claim Entry section of the DDE manual for descriptions of the fields on the entire claim inquiry screen.
LAST NAME	The beneficiary's last name.
FIRST INIT	The beneficiary's first initial.
TOT CHG	The total charges billed on the claim.
PROV REIMB	The provider's reimbursement amount. This field is signed to indicate positive or negative amounts.
PD DT	The date the claim was paid, partially paid, or processed.
CAN DT	The date the claim was canceled.
REAS	Reason code assigned by the FISS (refer to the on-line reason code file).
NPC	Non-payment code used by the system to deny or reject charges. Valid values are: B = Benefits exhausted C = Non-covered care (discontinued) E = First claim development (Contractor 11107) F = Trauma code development (Contractor 11108) G = Secondary claims investigation (Contractor 11109) H = Self reports (Contractor 11110) J = 411.25 (Contractor 11111) K = Insurer voluntary reporting (Contractor 11106) N = All other reasons for non-payment P = Payment requested Q = MSP Voluntary Agreements (Contractor 88888) Q = Employer Voluntary Reporting (Contractor 11105) R = Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely, or waiver of liability T = MSP Initial Enrollment Questionnaire (Contractor 99999) T = MSP Initial Enrollment Questionnaire (Contractor 11101) U = MSP HMO Cell Rate Adjustment (Contractor 55555) U = HMO/Rate Cell (Contractor 11103) V = MSP Litigation Settlement (Contractor 33333) W = Workers Compensation X = MSP cost avoided Y = IRS/SSA data match project, MSP cost avoided (Contractor 77777) Y = IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102) Z = System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim; this code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed 00 = COB Contractor (Contractor 11100) 12 = Blue Cross – Blue Shield Voluntary Agreements (Contractor 11112) 13 = Office of Personnel Management (OPM) Data Match (Contractor 11113) 14 = Workers' Compensation (WC) Data Match (Contractor 11114)

Field Name	Description
#DAYS	Not available in inquiry mode.

Revenue Codes

Select option '**13**' from the Inquiry Menu to access the Revenue Code Table Inquiry screen. This screen provides information regarding revenue codes that are billable for certain types of bills with the Fiscal Medicare contractor's system. This should be referenced when you need to determine:

- The type of revenue codes that are allowed with certain types of bills
- If a HCPCS code is required
- If a unit is required
- If a rate is required

To start the inquiry, type in the revenue code (four digits – ex: 0550) about which you are inquiring and press **[ENTER]**.

Revenue Code Table Inquiry Screen (MAP1761) - Field descriptions are provided in the table following Figure 25.

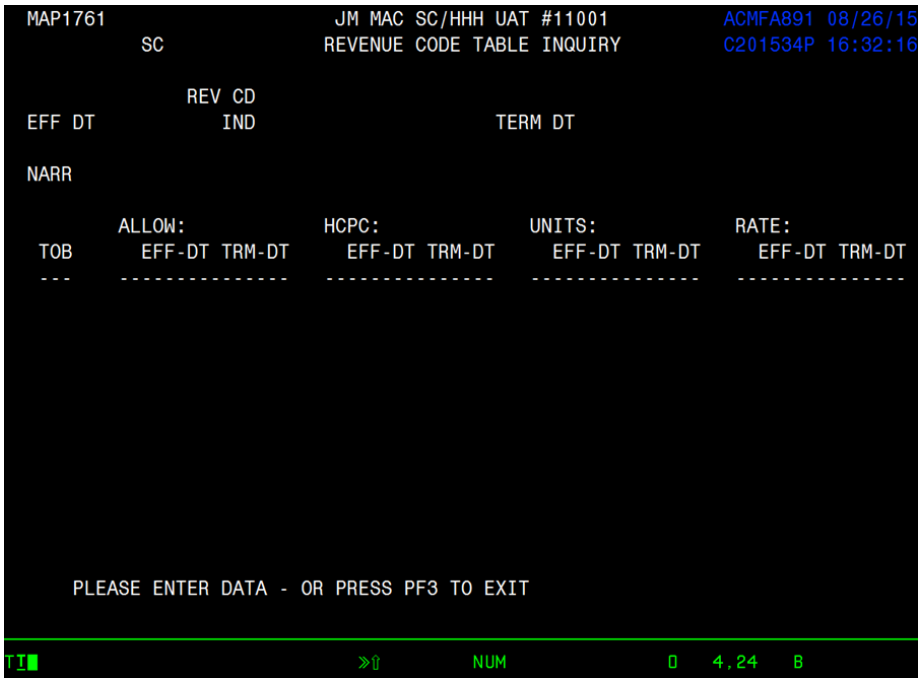


Figure 25 – Revenue Code Table Inquiry Screen

Field Name	Description
REV CD	Type the revenue code (0001-9999) that identifies a specific accommodation, ancillary service or billing calculation.
EFF DT	Date the code became effective/active.
IND	The effective date indicator instructs the system to either use the 'from' date on the claim or the System Run Date to perform edits for this revenue code. Valid codes are: F = From date R = Receipt date D = Discharge date
TERM DT	Date the code was terminated/no longer active.
NARR	English-language description of the code.
TOB	Identifies all Type of Bill codes within the Medicare Part A system that are allowed by Medicare.

Field Name	Description
ALLOW EFF-DT TRM DT	Identifies whether the revenue code is currently valid for a specific Type of Bill. Valid values are: Y = Yes N = No
HCPC EFF-DT TRM-DT	Identifies whether a Healthcare Common Procedure Code (HCPC) is required from specific types of providers for this Revenue Code by Type of Bill. Valid values are: Y = HCPC required for all providers N = HCPC not required V = Validation of HCPC is required F = HCPC required only for claims from free-standing ESRD facility H = HCPC required only for claims from hospital-based ESRD facility
UNITS EFF-DT TRM-DT	Identifies if the revenue code requires units to be present for a specific Type of Bill. Valid values are: Y = Yes N = No
RATE EFF-DT TRM-DT	Identifies if the revenue codes require a rate to be present for a specific Type of Bill. Valid values are: Y = Yes N = No

HCPC Inquiry

Select option '**14**' from the Inquiry Menu to access the HCPC Inquiry screen. This screen displays the current rate utilized to price specific outpatient services identified by a HCPCS code. The FISS does **pre-payment** processing of HCPCS codes for laboratory services; but Radiology, Ambulatory Surgery Center (ASC), Durable Medical Equipment (DME), and Medical Diagnostics HCPC service codes are processed **post-payment**.

To start the inquiry process, enter the HCPCS code and the Locality code, then press **[ENTER]**.

HCPC Inquiry Screen (MAP1771) – Field descriptions for the HCPC Inquiry screen are provided in the table following Figure 26.

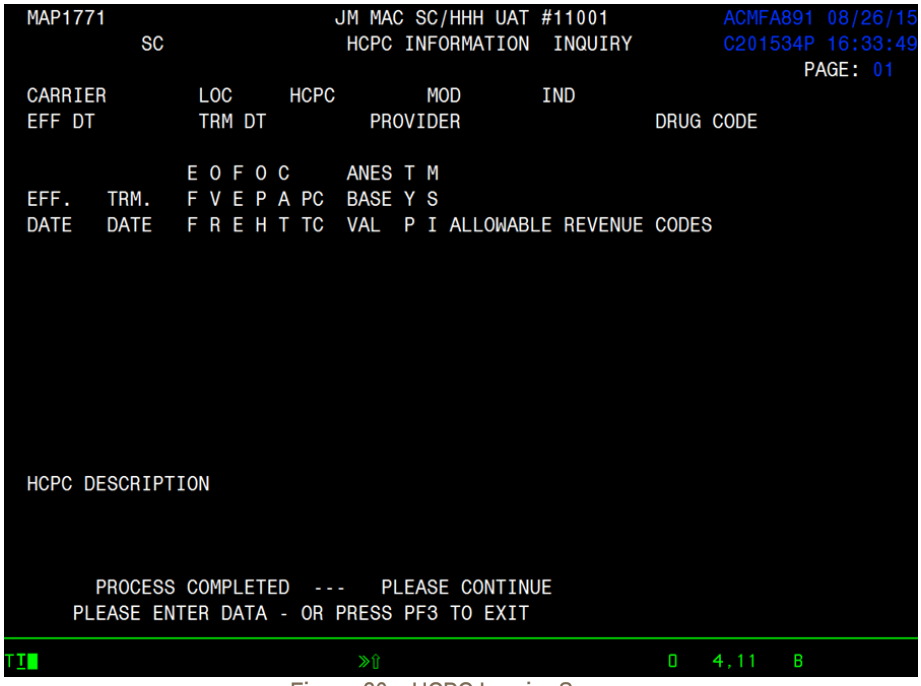


Figure 26 – HCPC Inquiry Screen

Field Name	Description
CARRIER	The Medicare contractor identification number.
LOC	The area (or county) where the provider is located. This field accepts as a valid value only the six **locality codes** entered on the Provider File and '01'. If a HCPC does not exist for the specific locality, the system will default to a '01', except for 90743 with a locality of '00'.
HCPC	Type the five-digit HCPC code to view.
MOD	This field identifies Multiple fees for one HCPC code based on the presence or absence of a modifier in this field. The default value is blank unless a valid modifier is entered for the HCPC.
IND	HCPC Indicator-this field is not used in DDE.
EFF DT	This field identifies the National Drug Code effective date.
TRM DT	This field identifies the National Drug Code termination date.
PROVIDER	This field identifies the identification number of the Alias Provider.
DRUG CODE	This field identifies whether the HCPC is a drug. 'E' The HCPC is a drug ' ' The HCPC is not a drug
EFF DT	This field identifies when the change in pricing went into effect. MMDDYY format.
TRM DT	This field identifies the termination date for each rate listed for this HCPC.
EFF	Effective Date Indicator: This indicator instructs the system to use From/Through dates on claims or use the system run date to perform edits for this particular HCPC date. Valid values are: R = Receipt Date F = From Date D = Discharge Date *Note: This field is displayed on the screen as: E F F
OVR	The override code instructs system in applying the services to the beneficiary deductible and coinsurance. Valid values are: 0 = Apply deductible and coinsurance 1 = Do not apply deductible 2 = Do not apply coinsurance 3 = Do not apply deductible or coinsurance 4 = No need for total charges (used for multiple HCPC for single revenue code centers) 5 = RHC or CORF psychiatric M = EGHP (may only be used on the 0001 total line for MSP) N = Non-EGHP (may only be used on the 0001 total line for MSP) Y = IRS/SSA data match project; MSP cost avoided *Note: This field is displayed on the screen as: O V R
FEE	Displays the fee indicator received in the Physician Fee Schedule file. Valid values include: B = Bundled Procedure R = Rehab/Audiology Function Test/CORF Services ' ' = Space *Note: This field is displayed on the screen as: F E E

Field Name	Description
OPH	The Outpatient Hospital Indicator, with six occurrences, displays the outpatient hospital indicator received in the Physician Fee Schedule abstract test file. Valid values are: 0 = Fee applicable in Hospital Outpatient Setting 1 = Fee not applicable in Hospital Outpatient Setting ' ' = Space *Note: This field is displayed on the screen as: O P H
CAT	Category Code: This field identifies the CMS category of the DME equipment. '1' Inexpensive or routinely purchased DME '2' DME items requiring frequent maintenance and substantial servicing '3' Certain customized DME items '4' Prosthetic or orthotic devices '5' Capped rental DME items '6' Oxygen and oxygen equipment *Note: This field is displayed on the screen as: C A T
PCTC	Professional Component/Technical Component: This field identifies the indicator that is added to the Comprehensive Outpatient Rehabilitation Facility (CORF) extract of the Medicare Physician Fee Schedule Supplementary File. This is used to identify professional services eligible for the Health Professional Shortage Area (HPSA) bonus payments. This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. This is a one-position alphanumeric field, with up to 40 occurrences. The valid values are: PC/TC — HPSA Payment Policy '0' Physician service codes '1' Diagnostic Tests for Radiology Services, '2' Professional component only. '3' Technical component only. '4' Global test only codes. '5' Incident codes, payment of the HPSA bonus may not be made by Medicare for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. '6' Laboratory physician interpretation codes. '7' Physical therapy service, payment of the HPSA bonus may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist. '8' Physician interpretation codes, payment of the HPSA bonus may be made for certain CPT codes. '9' Not applicable, concept of PC/TC does not apply *Note: This field is displayed on the screen as: PC TC
ANES BASE VAL	Identifies the anesthesia base values.

Field Name	Description
TYP	This field identifies whether other HCPCS originated from the Medicare Physician Fee Schedule (MPFS) database files and the fee rate. Valid values are: 'M' – Originated from MPFS database files ' ' – Did not originate from the MPFS database files *Note: This field is displayed on the screen as: T Y P
MSI	This field identifies the Multiple Service Indicator (MSI). *Note: This field is displayed on the screen as: M S I
ALLOWABLE REVENUE CODES	Billable UB-04 revenue codes for the HCPC entered. The fourth digit of the revenue code may be stored with an 'X' indicating it is variable. By leaving this field blank, the system will allow a HCPC on any revenue code.
HCPC DESCRIPTION	Narrative for the HCPC.

Diagnosis & Procedure Code Inquiry – ICD-9

Select option '**15**' from the Inquiry Menu to access the ICD-9-CM Code Inquiry screen. This screen displays an electronic description for the ICD-9-CM Codebook. This screen should be used as reference for ICD-9-CM code(s) to identify a specific diagnosis code or inpatient surgical procedure code for a related bill. To inquire about an ICD-9-CM diagnosis code, type the three-, four-, or five-digit code in the STARTING ICD9 CODE field. If more than one ICD-9 code is listed, review the most current effective date and termination date. To make additional ICD-9-CM inquiries type new information over the previously entered data.

To inquire about an ICD-9-CM procedure code, type the letter P followed by the three- or four-digit procedure code in the STARTING ICD9 CODE field. Do not type the decimal point or zero-fill the code. If the code entered requires a fourth and/or firth digit, an asterisk (*) will appear after the description. If an invalid code is entered, the system will select the nearest code.

ICD-9-CM Code Inquiry Screen (MAP1731) - Field descriptions are provided in the table following Figure 27.

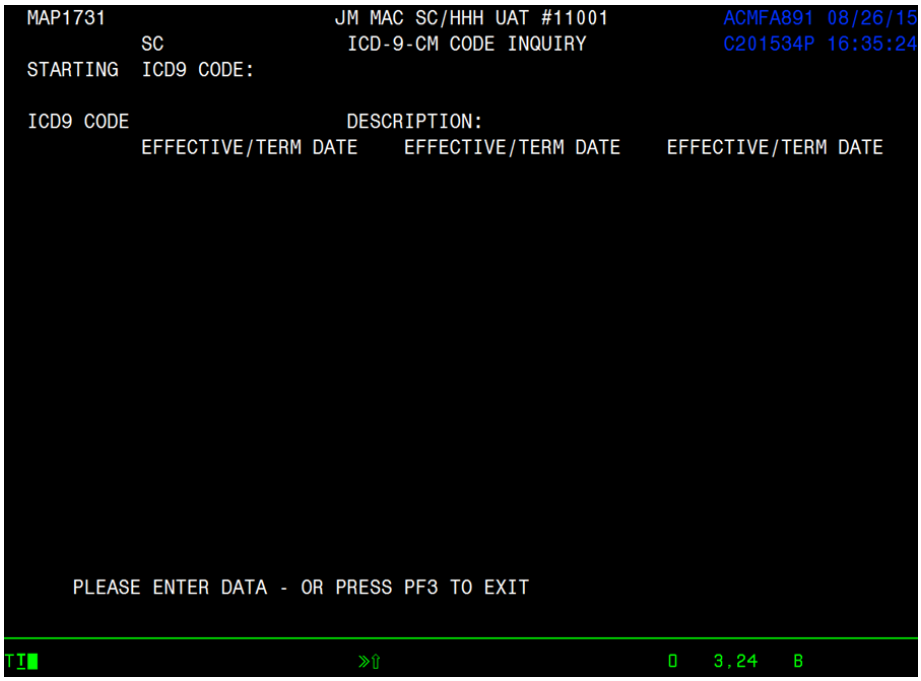


Figure 27 – ICD-9-CM Code Inquiry Screen

Field Name	Description
STARTING ICD-9 CODE	To view all ICD-9-CM codes, press [ENTER] in this field. The ICD-9-CM code is used to identify a specific diagnosis(ses) or inpatient surgical procedure(s) relating to a bill, which may be used to calculate payment (i.e., DRG) or make medical determination relating to a claim.
ICD-9 CODE	The specific ICD-9 code to be viewed.
DESCRIPTION	A description of ICD-9 code.
EFFECTIVE/ TERM DATE	The effective date of the program and the program ending date (both in MMDDYY format).

Adjustment Reason Code Inquiry

Select option '**16**' from the Inquiry Menu to access the Adjustment Reason Codes Inquiry screen. This screen provides an on-line access method to identify a two-digit adjustment reason code and a narrative description for the adjustment reason code. It can also be used to validate the adjustment reason code entered on an adjustment.

To start the inquiry process, type in an adjustment reason code and press **[ENTER]**, or just press **[ENTER]** and a list of adjustment reason codes will be displayed.

Adjustment Reason Codes Inquiry Selection Screen (MAP1821) - Field descriptions are provided in the table following Figure 28.

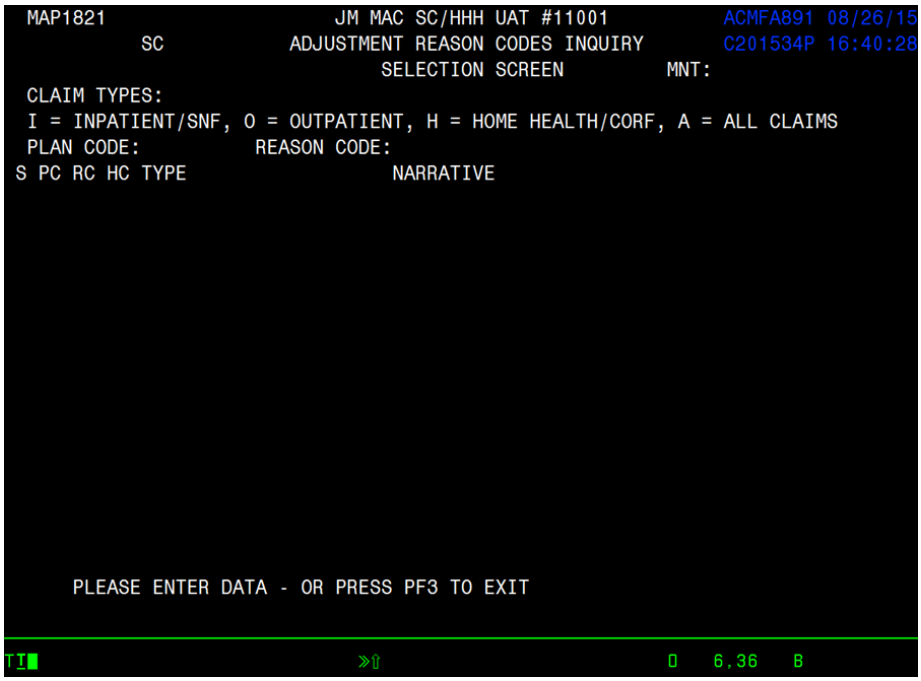


Figure 28 – Adjustment Reason Codes Inquiry Selection Screen

Field	Description
CLAIM TYPES	Describes the claim types identified for each adjustment reason code.
PLAN CODE	Differentiates between plans (Intermediaries) that share a processing site. The home/host site is considered '1' by the system. It is the number assigned to the site on the System Control file. Valid values are 1-9.
REASON CODE	To view a specific adjustment reason code, enter the value in this field. To view all adjustment reason codes, press [ENTER] in this field. There are hard-coded and user-defined codes. *PRO Review Code letters are indicated in brackets.
S	Selection – Used to view information for a particular code. To select an adjustment reason code, tab to desired code, enter '**S**' in the selection field, and press [ENTER].
PC	The Plan Code differentiates between plans (Intermediaries) that share a processing site. The home or host site is considered '1' by the system. It is the number assigned to the site on the System Control file. Valid values are 1-9.
RC	Displays the adjustment reason code. To review a particular adjustment reason code, enter the adjustment reason code value in this field.
HC	**HIGLAS Adjustment Reason Code**: This field identifies the Healthcare Integrated Ledger Accounting System (HIGLAS) adjustment reason code. This is a two-position alphanumeric field. NOTE: This field only displays on NON-HIGLAS sites.
TYPE	Displays the type of claim type associated with this reason code when a valid adjustment reason code is entered. Valid values are: I = Inpatient/SNF O = Outpatient H = Home Health/CORF A = All Claims
NARRATIVE	The narrative provides a short description for the adjustment reason code.

Reason Codes Inquiry

Select option '**17**' from the Inquiry Menu to access the Reason Codes Inquiry screen. Reason codes are applied to all claims processed in FISS. There can be one or more reason codes applied to a claim. This screen displays the narrative for the reason code(s) assigned to the claim. For claims that are Returned to the Provider (RTP) for correction, rejected or denied, the narrative also explains the error that was identified on the claim. For RTP claims, the narrative may also explain what fields need to be changed or completed in order to resubmit the claim for processing. The Reason Codes File contains the following data:

- Reason code identification number and effective/termination date
- Alternative reason code identification number and effective/termination date
- Status and location set on the claim
- Post payment location
- Reason code narrative
- Clean claim indicator
- Additional Development Request (ADR) orbit counter and frequency

To start the inquiry process, enter the five-digit numeric reason code applied to the claim and press **[ENTER]**. To make additional inquiries, type over the reason code with next reason code and press **[ENTER]**.

Reason Codes Inquiry Screen (MAP1881) - Field descriptions are provided in the table following the examples shown in Figures 29.

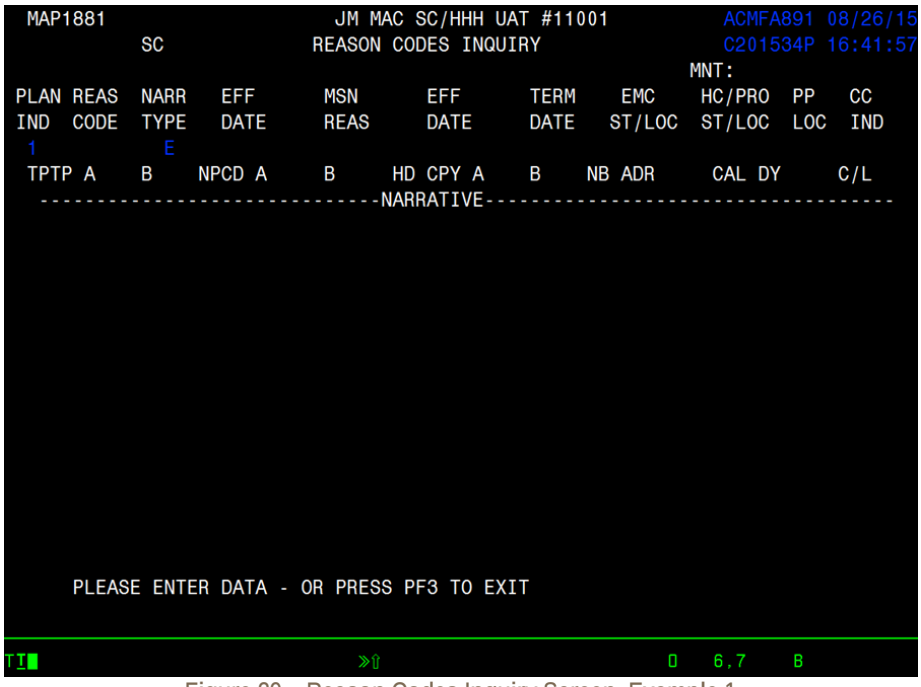


Figure 29 – Reason Codes Inquiry Screen, Example 1

Field Name	Description
MNT	Identifies the last date the reason code was updated.
PLAN IND	Plan Indicator. All FISS shared maintenance customers will be '1'; the value for FISS shared processing customers will be determined at a later date.
REAS CODE	Identifies a specific condition detected during the processing of a record.
NARR TYPE	The 'type' of reason code narrative provided. This field defaults to 'E' for external message.
EFF DATE	Identifies the effective date for the reason code or condition.

Field Name	Description
MSN REAS	The Medicare Summary Notice reason code is used when MSN's requiring BDL messages are produced. The reason code on the claim will be tied to a specific MSN reason code on the reason code file that will point to a specific MSN message on the ACS/MSN file.
EFF DATE	Effective date for the MSN reason code.
TERM DATE	Termination date for the MSN reason code.
EMC ST/LOC	Identifies the status and location to be set on an automated claim when it encounters the condition for a particular reason code. If it is the same for both hard copy and EMC claims, the data will only appear in the hard copy category and the system will default to the hard copy claims for action on EMC claims.
HC/PRO ST/LOC	Hardcopy/Peer Review Organization status and location code for hard copy (paper) and peer review organization claims. This is the path DDE will follow.
PP LOC	This field identifies the five-position alphanumeric post pay location of 'B75XX'.
CC IND	The clean claim indicator instructs the system whether to pay interest or not if applicable.
TPTP A	Tape-to-tape Flag indicator for Part A, which controls the flow of the claim to CWF, to the provider via the remittance advice, to the PS&R system and for counting the claim for workload purposes.
B	Tape-to-tape Flag indicator for Part B.
NPCD A	The Non-pay code for Medicare Part A, which identifies the reason for Medicare's decision not to make payment.
B	The Non-pay code for Medicare Part B, which identifies the reason for Medicare's decision not to make payment.
HD CPY A	This field instructs the system to generate a specific hardcopy document during the claim process on a Medicare Part A claim.
B	This field instructs the system to generate a hardcopy document during the claim process on a Medicare Part B claim.
NB ADR	This field identifies the number of times an Additional Documentation Request (ADR) form is to be generated. Identified by a '1' or a '2'.
CAL DY	This field identifies the number of calendar days a claim is to orbit after the generation of an ADR.
C/L	This field identifies if the reason code has been has been depicted as applying to the Claim or Line.
NARRATIVE	This field displays the description for the reason code.

Press [F8] on the Reason Codes Inquiry screen to display the ANSI Related Reason Codes Inquiry screen (Figure 30). This screen provides the ANSI reason code equivalent to the FISS reason code, which can also be accessed through option 68 from the Inquiry Menu screen. Press [F7] to return to the Reason Codes Inquiry screen.

ANSI Related Reason Codes Inquiry Screen (MAP1882) – Field Descriptions are in the table following Figure 30.

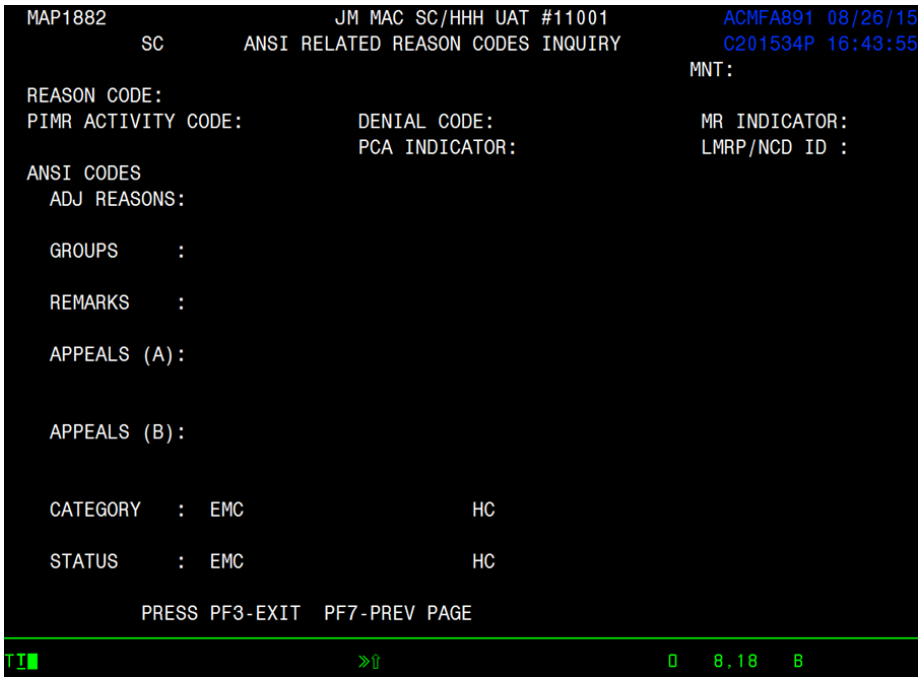


Figure 30 – ANSI Related Reason Codes Inquiry Screen

Field Name	Description
REASON CODE	This field will display the reason code entered on MAP1881 described in Figure 29.
MNT	Identifies the last date the reason code was updated.
PIMR ACTIVITY CODE	**Program Integrity Management Reporting (PIMR) Activity Code**: This field identifies the PIMR activity code for which the reason code is being categorized. This is a two-position alphanumeric field and is protected. The valid values are: 'AI' = Automated CCI Edit 'AL' = Automated Locally Developed Edit 'AN' = Automated National Edit 'CP'' = Prepay Complex Probe Review 'DB' = TPL or Demand Bill Claim Review 'MR' = Manual Routine Review 'PS' = Prepay Complex Provider Specific Review 'RO' = Reopening 'SS' = Prepay Complex Service Specific Review

Field Name	Description
DENIAL CODE	**Denial Reason Code**: This field identifies the PIMR Denial reason code that is being categorized (applies to all contractors). This is a six-position alphanumeric field and is protected. The valid values are: 'NOPIMR' = Default '100001' = Documentation Does Not Support Service '100002' = Investigation/Experimental '100003' = Item/Services Excluded From Medicare Coverage '100004' = Requested Information Not Received '100005' = Services Not Billed Under The Appropriate Revenue Or Procedure Code (Include Denials Due To Unbundling In This Category '100006' = Services Not Documented In Record '100007' = Services Not Medically Reasonable And Necessary '100008' = Skilled Nursing Facility Demand Bills '100009' = Daily Nursing Visits Are Not Intermittent/ Part Time '100010' = Specific Visits Did Not Include Personal Care Service '100011' = Home Health Demand Bills '100012' = Ability To Leave Home Unrestricted '100013' = Physician's Order Not Timely '100014' = Service Not Ordered/Not Included In Treatment Plan '100015' = Services Not Included In Plan Of Care '100016' = No Physician Certification (E.G. Home Health) '100017' = Incomplete Physician Order '100018' = No Individual Treatment Plan '100019' = Other
MR INDICATOR	**Medical Review Indicator**: This field identifies whether or not the service received complex manual medical review. This is a one-position alphanumeric field. The valid values are: ' ' = The services did not receive manual medical review (default value). 'Y' = Medical records received. This service received complex manual medical review. 'N' = Medical records were not received. This service received routine manual medical review.
PCA INDICATOR	**Progressive Correction Action (PCA) Indicator**: This field identifies the PCA indicator. This is a one-position alphanumeric field. The valid values are: ' ' = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files. 'Y' = The Medical Policy Parameter is PCA-related and is included in the PCA transfer files. 'N' = The Medical Policy Parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID	**Local Medical Review Policy (LMRP) and/or National Coverage Determination (NCD) Identification Number**: This field identifies the LMRP/NCD identification numbers, which are assigned to the FMR reason code for reporting on the beneficiaries Medicare Summary Notice. This is an eleven-position alphanumeric field, with five occurrences. The values for the LMRP are user defined and the NCD is CMS defined.
ANSI CODES	
ADJ REASONS	**Adjustment Reason Codes**: This is the ANSI reason code that is related to the FISS reason code. This is a three-digit alphanumeric field with ten occurrences.
GROUPS	**Group Codes**: The group code associated with the ANSI Reason code. This is a two-digit field with four occurrences. Valid values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PR = Patient Responsibility

Field Name	Description
REMARKS	The Remarks describe the reason for non-payment. This is a five-digit alphanumeric field that displays up to four occurrences.
APPEALS (A)	**ANSI Appeals-A Code**: These codes are used for inpatient only. This is a five-digit alphanumeric field that displays up to 20 occurrences.
APPEALS (B)	**ANSI Appeal-B Codes**: These codes are used for outpatient only. This is a five-digit alphanumeric field that displays up to 20 occurrences.
CATEGORY	
EMC	**Electronic Media Claim Category Code**: This field identifies the EMC category of the claim that is returned on a 277 claim response. This is a three-digit alphanumeric field.
HC	**Hard Copy Claim Category Code**: This field identifies the Hard Copy category of the claim that is returned on a 277 claim response. This is a three-digit alphanumeric field.
STATUS	
EMC	**Electronic Media Claim Status Code**: This field identifies the EMC status of the claim that is returned on a 277 claim response. This is a four-digit alphanumeric field.
HC	**Hard Copy Claim Status**: This field identifies the Hard Copy status of the claim that is returned on a 277 claim response. This is a four-digit alphanumeric field.

OSC Repository Inquiry

The purpose of the OSC (Occurrence Span Code) Repository Inquiry screen is to display the occurrence span code repository record. Up to three occurrences can display on a page. Specific occurrences can be displayed by typing a page number in the PG field at the upper left hand corner of the screen. Select Option 1A from the inquiry screen to access this screen.

OSC Repository Inquiry Screen (MAP11A1) – Field descriptions are in the table below Figure 31.

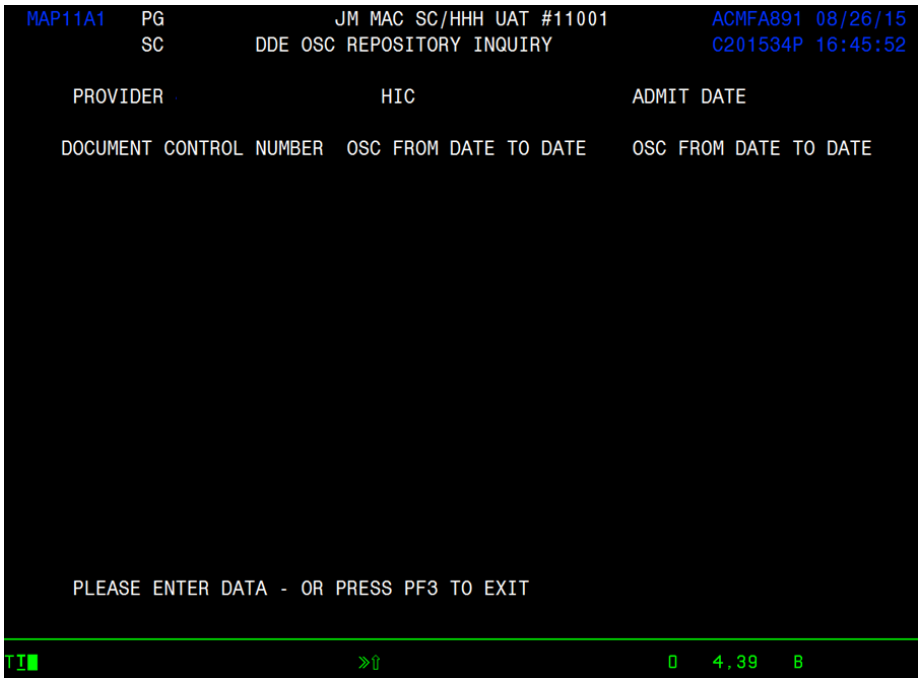


Figure 31 – DDE OSC Repository Inquiry

Field Name	Description
PROVIDER	This field displays the provider identification number.

Field Name	Description
HIC	This field displays the beneficiary's Medicare number as shown on the Medicare card.
ADMIT DATE	This field identifies the patient's admission date in MM/DD/YY format.
DOCUMENT CONTROL NUMBER	This field displays the claim identification number.
OSC	The Occurrence Span Code that identifies events that relate to the payment of the claim.
FROM DATE	This field identifies the beginning of an event that relates to the payment of the claim.
TO DATE	This field identifies the ending date of the event that relates to the payment of the claim.

Claims Count Summary

Select option '**56**' from the Inquiry Menu to access the Claim Summary Totals Inquiry screen. This screen provides a mechanism for providers to obtain information on:

- Total number of pending claims
- Total charges billed
- Total reimbursement for claims in each FISS status/location

The data on this screen updates with each nightly FISS cycle. Palmetto GBA recommends that providers review this screen at the start of each day to monitor the progress of submitted claims.
Press **[ENTER]** to display the data applicable to the provider number identified, **or** you can type in a specific status/location or category type to narrow the search.

Claim Summary Totals Inquiry Screen (MAP1371) – Field descriptions are provided in the table following Figure 32.

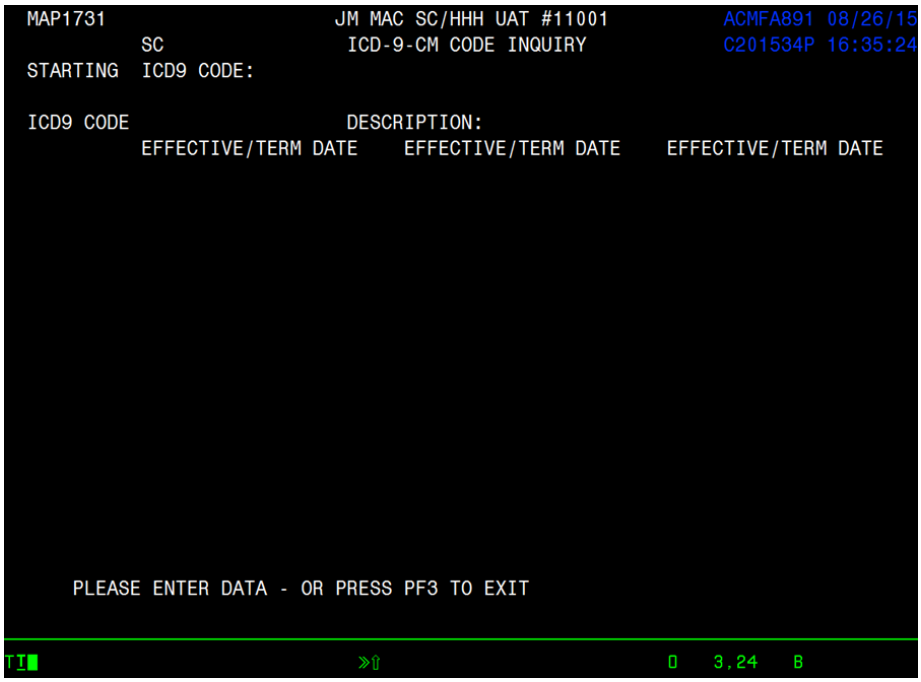


Figure 32 – Claim Summary Totals Inquiry Screen

Field Name	Description
PROVIDER	Automatically filled with the provider number, but accessible if the provider is authorized to view other provider numbers.

Field Name	Description
S/LOC	The status/location of the claim can be used as search criteria.
CAT	The category can be used as search criteria.
NPI	Identifies the provider's National Provider Identifier (NPI).
S/LOC	The status/location identifies the condition of the claim and/or location of the claim.
CAT	The Bill Category identifies the type of claims in specific locations by Type of Bill. In addition, a value that identifies the total claim number for each status/location. Valid values include: NN = First two digits of any TOB appropriate to the provider; e.g., 11, 13, 32, 72, etc. MP = Medical Policy – Medical policy applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code **is** a 5. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. NM = Non-Medical Policy – Applies to claims in a status of 'T' and a location of B9997 only. It identifies RTP'd claims where the first digit of the primary reason code **is not** a 5. Claims in this category are also counted under the standard bill category. Claims in this category are not included in the total count (TC) category. AD = Adjustments – Within each status/location. Claims in this category are also counted under the standard bill category. Therefore, claims in this category **are not** included in the total count (TC). TC = Total Count – Is the total within each status/location **excluding** claims with a category of AD, MN, or MP. GT = Grand Total – For the provider of all categories in all status/locations. This total will print at the beginning of the listing and associated status/locations will be blank. The grand total is displayed only when the total by Provider is requested.
CLAIM COUNT	The total claim count for each specific status/location.
TOTAL CHARGES	The total dollar amount accumulated for the total number of claims identified in the claim count.
TOTAL PAYMENT	The total dollar payment amount that has been calculated by the system. This is an accumulated dollar amount for the total number of claims identified in the claim count. For those claims suspended in locations prior to payment calculations, the total payment will equal zeros.

Home Health Payment Totals

Select option '67' from the Inquiry Menu to access the Home Health Payment Totals Screen. This screen displays the total outlier payments as well as the total amount paid to the home health agency during the calendar year.

Home Health Payment Totals Inquiry Screen (MAP1B41) - Field descriptions are provided in the table following Figure 33.

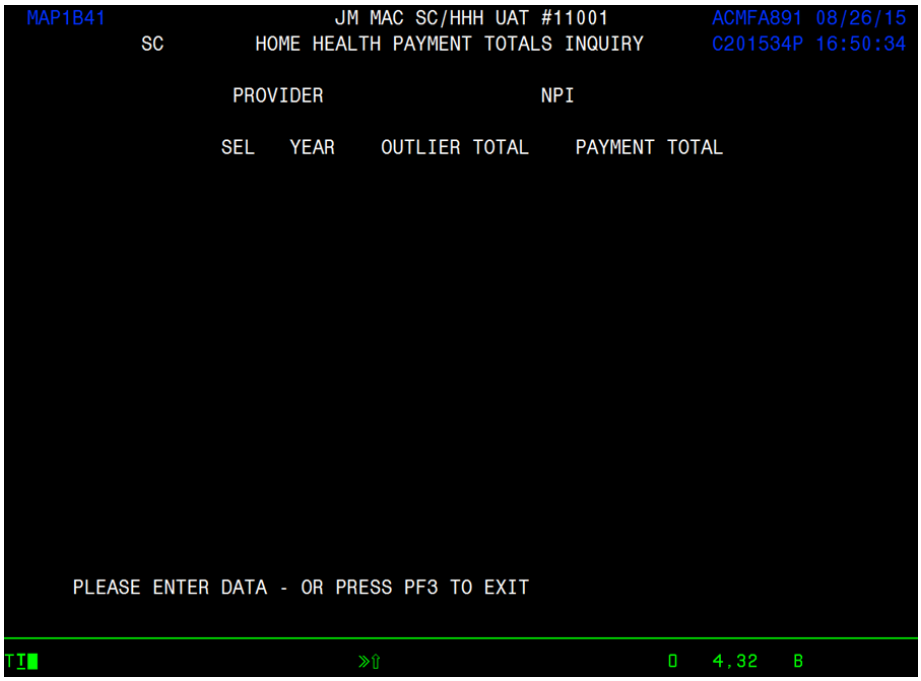


Figure 33 – Home Health Payment Totals Inquiry Screen

Field Name	Description
PROVIDER	This field identifies the provider number.
NPI	This field identifies the provider's National Provider Identifier (NPI) number.
SEL	This field identifies the detail records for the selected Total Record, and will display on the second Nap. The valid value is: 'S' = Select
YEAR	This field identifies claim information for that year by entering an 'S' by that year in CCYY format.
OUTLIER TOTAL	This field identifies the Outlier total.
PAYMENT TOTAL	This field identifies the total amount of payment.

ANSI Reason Code Inquiry

Select option '**68**' from the Inquiry Menu to access the ANSI (American National Standard Institute) Reason Codes Inquiry Selection Screen. This screen displays the remark codes that appear on both the standard paper remittance advice and the electronic remittance advice. These codes signify the presence of service-specific Medicare remarks and informational messages that cannot be expressed with a reason code.

To start the inquiry process, enter the option for which you wish to obtain information (e.g., C for claim adjustment reason codes) in the Record Type field, and the specific code (e.g., 45). To obtain the information for a specific ANSI reason code, select 'A', enter the code and press **[ENTER]**, or you can leave the Record Type field blank, press **[ENTER]** and a list of ANSI reason codes will display.

ANSI Reason Code Inquiry Screen (MAP1581) – Field descriptions are provided in the table following Figure 34

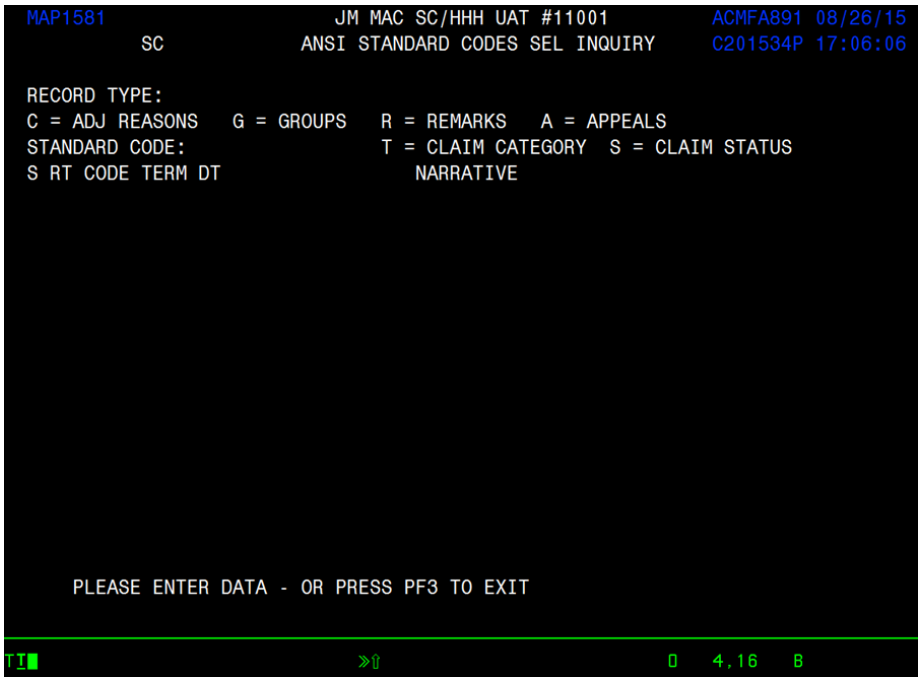


Figure 34 – ANSI Related Reason Codes Inquiry Selection Screen

Field Name	Description
RECORD TYPE	Identifies the ANSI record type for the standard code for inquiry or updating. Enter the value for the type of code you want to view. Valid values are: C = Claim adjustment reason G = Group codes R = Remittance Advice Remark A = ANSI Reason Code T= Claim category S= Claim Status
STANDARD CODE	The standard code within the above record type for inquiry or updating. Enter the code needed or press [Enter] and the entire list of codes for the record type selected above will be displayed. If both record and standard codes are present, the information for that code will be displayed. Otherwise, all ANSI codes will be displayed in record type/ standard code sequence.
S	Code selection field to select a specific code from the listing.
RT	The record type selected.
CODE	The standard code selected.
TERM DT	The date the ANSI standard code is deactivated in MMDDYY format.
NARRATIVE	The description of the standard code. This is the only field that can be updated for a standard code.

ANSI Reason Code Narrative

When the entire list of codes is displayed for a specific Record Type, to display the entire narrative for one specific ANSI code:

1. Type an '**S**' in the S (Select) field to view the entire narrative for the ANSI code. Figure 35 provides an example of the list that displayed for record type 'A'.

ANSI Standard Codes Selection Inquiry Screen (MAP1581) –Figure 35. Field descriptions are provided in the table following Figure 34

```
MAP1581                    JM MAC SC/HHH UAT #11001          ACMFA891 08/26/15
          SC             ANSI STANDARD CODES SEL INQUIRY     C201534P 17:08:33

RECORD TYPE: A
C = ADJ REASONS   G = GROUPS   R = REMARKS   A = APPEALS
STANDARD CODE:                 T = CLAIM CATEGORY  S = CLAIM STATUS
S RT CODE TERM DT                 NARRATIVE
  A MA01         ALERT: IF YOU DO NOT AGREE WITH WHAT WE APPROVED FOR THESE
  A MA02         ALERT: IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAV
  A MA03  111805 IF YOU DO NOT AGREE WITH THE APPROVED AMOUNTS AND $100 OR M
  A MA04  110407 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTIFY
  A MA05  101603 INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL EN
  A MA06  080104 INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
  A MA07  110407 THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID F
S A MA08  110407 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSU
  A MA09  110407 CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YO
  A MA10  110407 THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU
  A MA100 110407 MISSING/INCOMPLETE/INVALID DATE OF CURRENT ILLNESS, INJURY
  A MA101 110407 A SKILLED NURSING FACILITY (SNF) IS RESPONSIBLE FOR PAYMENT
  A MA102 080104 MISSING/INCOMPLETE/INVALID NAME OR PROVIDER IDENTIFIER FOR
  A MA103 110407 HEMOPHILIA ADD ON.
  A MA104 013104 MISSING/INCOMPLETE/INVALID DATE THE PATIENT WAS LAST SEEN O
      PROCESS COMPLETED  ---   PLEASE CONTINUE
  PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD

TI                              »⇧                          0   16,3   B
```

Figure 35 – ANSI Related Reason Codes Inquiry Selection Screen, ANSI Reason Code List

2. Press **[ENTER]** to display the ANSI Standard Codes Inquiry screen (see Figure 36).

ANSI Standard Reason Codes Inquiry Screen (MAP1582) –Figure 36. Field descriptions are provided in the table following Figure 36.

```
MAP1582                    JM MAC SC/HHH UAT #11001          ACMFA891 08/26/15
          SC            ANSI STANDARD REASON CODES INQUIRY   C201534P 17:10:46
                                                      MNT: SYSTEM   03/24/08

 RECORD TYPES ARE:
C = ADJ REASONS   G = GROUPS   R = REMARKS   A = APPEALS
                               T = CLAIM CATEGORY S = CLAIM STATUS
                          RECORD TYPE   : A        TERM DT  :  110407
                                                   EFF DT   :
                          STANDARD CODE : MA08

                          NARRATIVE:

 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSURER. WE DID
 NOT SEND THE CLAIM DATA AS THE OTHER INSURER IS NOT A MEDIGAP PLAN, OR
 YOU DO NOT PARTICIPATE IN MEDICARE.









      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE

TI                              »                           0   2,16   B
```

Figure 36 – ANSI Standard Codes Inquiry Screen

Field Name	Description
MNT	This field identifies the last operator who created or revised this record. This is a nine eight-position alphanumeric field. This field also identifies the date the screen was last accessed by the maintenance operator in the MM/DD/YY format.
RECORD TYPES ARE	This field displays the types of records that can be displayed on the screen.
RECORD TYPE	This field identifies the ANSI Record Type for the standard code that was selected on the previous screen. This is a one-position alphanumeric field. A = Appeals C = Adjustment Reasons G = Groups R = Remarks S = Claim status T = Claim category
TERM DT	This field identifies the termination date of the ANSI Standard Code deactivation. This is a six-digit field in MMDDYY format.
EFF DT	This field identifies the effective date of the ANSI Standard Code activation. This is a six-digit field in MMDDYY format.
STANDARD CODE	This field identifies the standard code within the above record type that is added. This is a five-digit alphanumeric field.
NARRATIVE	This is the narrative description of the standard code. This is an alphanumeric field that will display up to 70 characters with up to five screens.

Check History Inquiry

Select option '**FI'** from the Inquiry Menu to access the Check History screen. This screen lists Medicare payments for the last three issued checks, paid hardcopy or electronically. If you are interested in electronic payment, contact the EDI Department. Press **[ENTER]** and the last three checks issued by Medicare will display.

Note: The system will automatically enter your provider number into the PROVIDER (PROV) field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information. **[TAB]** to the PROV field and type in the provider number.

Check History Screen (MAP1B01) - Field descriptions for the Check History screen are provided in the table following Figure 37.

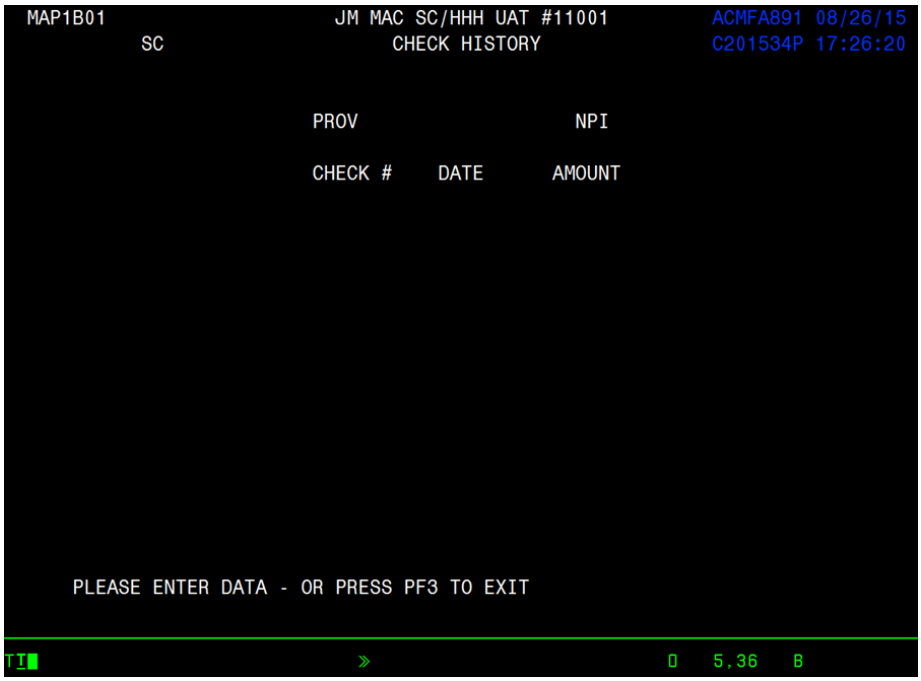


Figure 37 – Check History Screen

Field Name	Description
PROV	The Medicare assigned provider number.
NPI	The provider's National Provider Identifier (NPI) number.
CHECK #	The last three payments issued to the provider by Medicare. Leading zeros indicate a check. 'EFT' indicates electronic fund transfer.
DATE	The date when the payments were issued.
AMOUNT	The dollar amount of the last three payments issued to the provider.

Diagnosis & Procedure Code Inquiry – ICD10

Select option '**1B**' from the Inquiry Menu to access the ICD-10-CM Code Inquiry screen. This screen displays an electronic description for the ICD-10-CM Codebook. This screen should be used as reference for ICD-10-CM code(s) to identify a specific diagnosis code or inpatient surgical procedure code for a related bill. An effective date will be listed below each code and, if applicable, a termination date is also provided.

To inquire about an ICD-10-CM diagnosis code, type a 'D' in the DIAG/PROC field then tab to the STARTING ICD 10 CODE field and type in the code.

To inquire about an ICD-10-CM procedure code, type the letter 'P' in the DIAG/PROC field and tab to the STARTING ICD 10 CODE field and type in the code.

ICD-10-CM Code Inquiry Screen (MAP1C31) – Field descriptions are provided in the table following Figure 38.

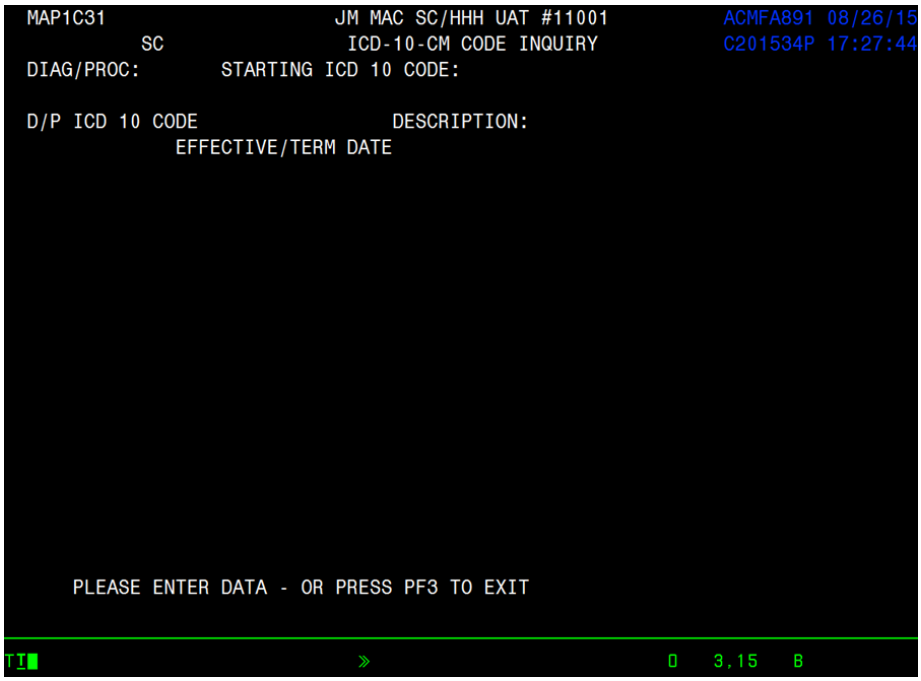


Figure 38 – ICD-10-CM Code Inquiry Screen

Field Name	Description
DIAG/PROC	This field identifies whether or not this is an ICD-10 diagnosis or procedure. Valid values are: 'D' = Diagnosis code being entered/updated 'P' = Procedure code being entered/updated
STARTING ICD 10 CODE	The ICD-10 code is used to identify a specific diagnosis(ses) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim.
D/P	This field identifies whether or not this is an ICD-10 diagnosis or procedure. This is a one-position alphanumeric field. The valid values are: 'D' = Diagnosis code being entered/updated 'P' = Procedure code being entered/updated
ICD-10 CODE	The ICD-10 code is used to identify a specific diagnosis(ses) or inpatient surgical procedure(s) relating to a bill which may be used to calculate payment (i.e., DRG) or to make medical determinations relating to a claim
DESCRIPTION	This field displays the description for the ICD-10 code.
EFFECTIVE/ TERM DATE	This field identifies the effective and/or termination date of the program.

SECTION 5 – CLAIM ENTRY

This section provides information on how to enter:
- UB-04s into the DDE format
- Electronic Roster Bills
- Hospice Election Statements

The Claims and Attachments Entry Menu (Main Menu option 02) may be used for online entry of patient billing information from the UB-04. Options are available to allow entry of various attachments. The UB-04 Claim Entry consists of six (6) separate screens/pages:

- **Page 01** Patient information (corresponds to form locators 1-41)
- **Page 02** Revenue/HCPCS codes and charges (corresponds to form locators 42-49)
- **Page 03** Payer information, diagnoses/procedure codes (corresponds to form locators 50-57 and 67-83)
- **Page 04** Remarks and attachments (corresponds to form locators 80)
- **Page 05** Other payer and MSP information (corresponds to form locators 58-66)
- **Page 06** MSP information, crossover and detail claim inquiry (**does not** correspond to any form locator)

*NOTE: MSP claims cannot be submitted or corrected in DDE.

General Information

- The online system defaults to the 111 type of bill for inpatient claims (option 20), 131 for outpatient claims (option 22), and 211 for SNF claims (option 24), 322 for Home Health claims (option 26), and 811 for Hospice claims (option 28). If you are entering a different type of bill, then type over the default with the correct type of bill.
- On the bottom of each screen is a list of the PF function keys and the functions they perform.
- Field names within DDE will not always follow the same order as found on the UB-04 claim form. In order to help alleviate confusion, the 'UB-04 X-REF' field on each page directs you to the field that correlates to the UB-04 form.
- For valid values associated with the claim entry field, please refer to your current Uniform Billing manual. The 'UB-04 X-REF' field will direct you to the field that correlates to the UB-04 form noted in the manual.

Transmitting Data

- When claim entry is completed, press **[F9]** to store the claim and transmit the data.
- If any information is missing or entered incorrectly, the DDE system will display reason codes on the bottom left side of the claim screen to alert you of any errors that need to be corrected. The claim will not transmit until it is free of front-end edit errors. A blank claim entry screen will display if the claim is successfully transmitted.
- Correcting errors:
- Press **[F1]** to see an explanation of the reason code. After reviewing the explanation, press **[F3]** to return to your claim and make the necessary correction(s). If more than one reason code appears, continue this process until all reason codes are eliminated and the claim is successfully captured by the system.
- If more than one reason code is present, pressing **[F1]** will always bring up the explanation of the first reason code unless the cursor is positioned over one of the other reason codes. Working through the reason codes in the order they are listed is the most efficient method. Eliminating the reason codes at the beginning of the list may result in the reason codes at the end of the list being corrected as well.

Note: The system will automatically enter your provider number into the OSCAR field. If the facility has multiple provider numbers, you will need to change the provider number to inquire or input information. **[TAB]** to the OSCAR field and type in the provider number.

Claim and Attachments Entry Menu (MAP1703)

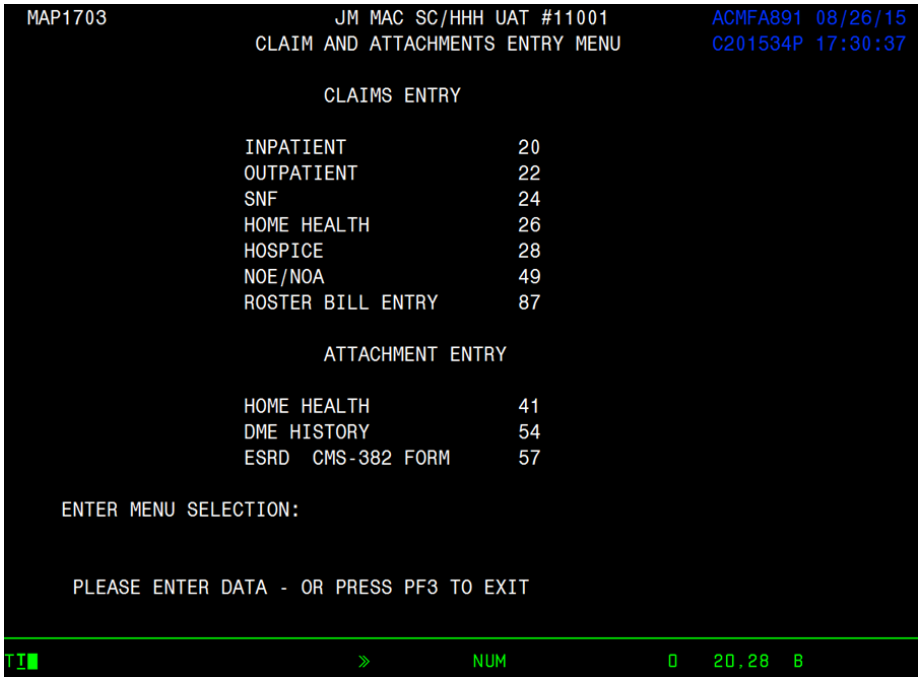


Figure 39 – Claim and Attachments Entry Menu

Electronic UB-04 Claim Entry

When entering UB-04s, select the option from the Claim and Attachments Entry Menu that best describes your Medicare line of business:

- Inpatient 20
- Outpatient 22
- SNF 24
- Home Health 26
- Hospice 28
- Hospice Elections 4

UB-04 Claim Entry – Page 1

After you select an option, page one of the UB-04 Claim Entry screen (Figure 40) will display. The screen will include the OSCAR (Provider Number), Type of Bill, and default Status/Location (S B0100). You must enter the beneficiary information (name, address, date of birth, etc.) and any other information needed to process the claim.

INST Claim Entry – Page 1 (MAP1711) – Field descriptions are provided in the table following Figure 40.

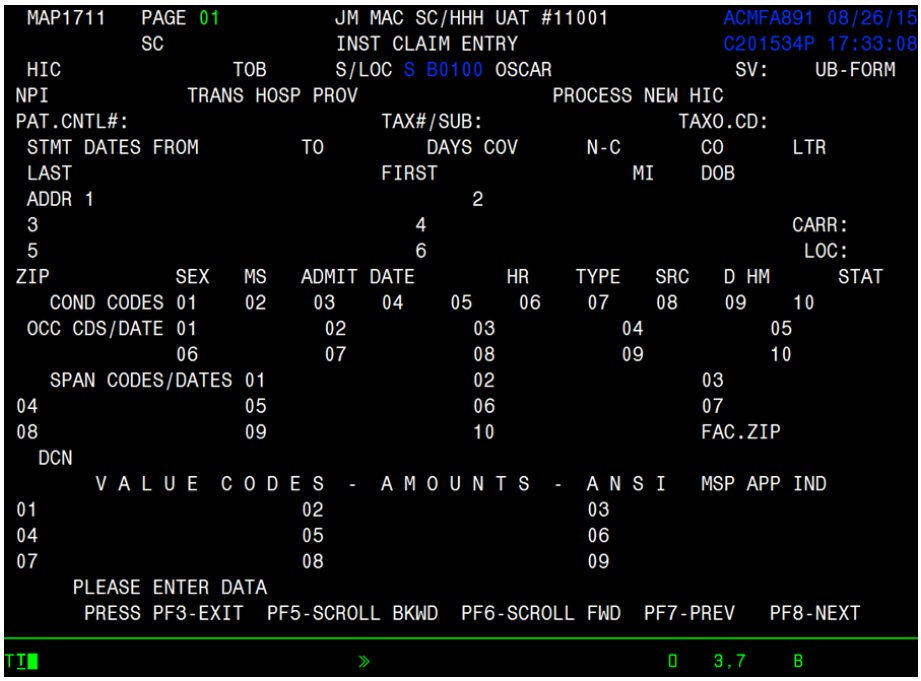


Figure 40 – UB-04 Claim Entry Screen, Page 1

*NOTE: The 'SC' field will display at the top of each claim page. This field can be used to navigate to any of the claim inquiry screens if desired during the claim entry process. (Ex: Enter '17' to navigate directly to the reason code inquiry screen). To navigate back to the claim page, press [F3].

Field Name	UB-04 X-Ref.	Description
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
OSCAR	57	Displays the identification number of the institution that rendered services to the beneficiary/patient. The system will automatically pre-fill the Medicare Oscar number when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, CORF, ORF) the Medicare Oscar number must be changed to reflect the provider you wish to submit claims for. If the Medicare Oscar number is not changed for your sub-units, the claims will be processed under the incorrect Oscar number.
SV		Suppress View: This field allows a claim to be suppressed.
UB-FORM		Identifies the type of claim to be processed. All claims must be entered on the same form type. Valid values are: '9' = UB-92 'A' = UB-04
NPI	56	This field identifies the National Provider Identifier number.
TRANS HOSP PROV		**Transferring Hospice Provider**: Displays the identification number of the institution that rendered services to the beneficiary/patient. System-generated for external operators that are directly associated with one provider. This number is assigned by CMS. This is a 13-digit

Field Name	UB-04 X-Ref.	Description
PROCESS NEW HIC	60	Identifies when the incorrect beneficiary health insurance claim number is present, and then the correct health insurance claim number can be keyed. ***Not applicable on new claim entries***. Valid values include: Y = Incorrect HIC is present E = The new HIC number is in a cross-reference loop ***or*** the new HIC entered is cross-referenced on the Beneficiary file and this cross-referenced HIC is also cross-referenced. The chain continues for 25 HIC numbers. S = The cross-referenced HIC number on the Beneficiary file is the same as the original HIC number on the claim.
PAT. CNTL#	3a	**Patient Control Number**: The patient's unique number assigned by the provider to facilitate retrieval of individual patient records and posting of the payment.
TAX #/SUB	5	This field identifies the number assigned to the provider by the Federal Government for tax reporting purposes.
TAXO.CD		This field identifies a collection of unique alphanumeric codes known as the provider taxonomy code. The code set is structured into three distinct levels including provider type, classification, and area of specialization.
STMT DATES FROM and TO	6	The statement covers (from and to) dates of the period covered by this bill (in MMDDYY format).
DAYS COV		Indicates the total number of covered days. This field is skipped on Home Health and Hospice claims. • Enter the total number of covered days during the billing period (within the 'From' and 'Through' dates in UB-04 X-REF 6 - Statement Covers Period), which are applicable to the cost report, including lifetime reserve days elected (for which hospital requested Medicare payment). • The numeric entry reported in this UB-04 X-REF should be the same total as the total number of covered accommodation units reported in UB-04 X-REF 46. • Exclude any days classified as non-covered (see UB-04 X-REF 8 - Non-covered Days) and leave of absence days. • Exclude the day of discharge or death (unless the patient is admitted and discharged the same day). Do not deduct days for payment made by another primary payer.
N-C		Indicates the total number of non-covered days. Enter the total number of non-covered days in the billing period. • Enter the total number of covered days during the billing period (within the 'From' and 'Through' dates in UB-04 X-REF 6 - Statement Covers Period). These days are not covered Medicare payment days on the cost report and the beneficiary will not be charged utilization for Medicare Part A Services. • The reason for non-coverage should be explained by occurrence codes (UB-04 X-REFs 31 - 34), and/or occurrence span code (UB-04 X-REF 35 - 36). Provide a brief explanation of any non-covered days not described via occurrence codes in UB-04 X-REF 80, Remarks. (Show the number of days for each category of non-covered days, e.g., '5 leave days'). • Day of discharge or death is not counted as a non-covered day. Do not deduct days for payment made by another primary payer.
CO		Co-Insurance Days are the inpatient Medicare hospital days occurring after the 60th day and before the 91st day. Enter the total number of inpatient or SNF co-insurance days.

Field Name	UB-04 X-Ref.	Description
LTR		Lifetime Reserve Days – This field is only used for hospital inpatient stays. Enter the total number of inpatient lifetime reserve days the patient elected to use during this billing period.
LAST	8a	Patient's last name.
FIRST	8a	Patient's first name.
MI	8a	Patient's middle initial.
DOB	10	The patient's date of birth (in MMDDYYYY format).
ADDR 1 – 6	9a – e	Patient's street address. Must input in fields 1 and 2. State is a 2-character field.
CARR		This field identifies the value codes carrier number. The carrier number is the identification number of the Medicare carrier as designated by the CMS. This field is a five-digit alphanumeric field. NOTE: The carrier and locality information is associated with the nine-digit service facility zip code on the claim record in an available space on MAP1711.
LOC		This field identifies the value codes locality code. The locality code is a specific location of a provider of services in a given state falling under the realm of a particular carrier's jurisdiction. It is a two-digit alphanumeric field. NOTE: The carrier and locality information is associated with the nine-digit service facility zip code on the claim record in an available space on MAP1711.
ZIP	9d	Patient's valid zip code (minimum of 5 digits).
SEX	11	The patient's sex. Refer to your UB-04 Manual for valid values.
MS		The patient's marital status. Not required. Refer to your UB-04 Manual for valid values.
ADMIT DATE	12	Enter date patient was admitted.
HR	13	Enter the hour the patient was admitted (for hospitals only).
TYPE	14	The type of admission. Enter the appropriate inpatient code that indicates the priority of the admission. Refer to your UB-04 Manual for valid values.
SRC	15	The source of admission. Enter appropriate code indicating the point of origin of the source of this admission. Refer to your UB-04 Manual for valid values.
D HM	16	Enter the time at which the patient was discharged from inpatient care (in HHMM format).
STAT	17	Indicates the patient's status at the ending service date in the period. Refer to your UB-04 Manual for valid values.
COND CODES (01 – 10)	18 – 28	The condition codes are used to identify conditions relating to this bill that may affect claim processing, up to 30 occurrences. Refer to your UB-04 Manual for valid values.
OCC CDS/ DATE (01 – 10)	31 – 34	The Occurrence Codes and Dates field consists of a two-digit alphanumeric code and a six-digit date in MMDDYY format. Report all appropriate occurrences, up to 30 occurrences. Refer to your UB-04 Manual for valid values.
SPANCODES/ DATES (01 – 10)	35 – 36	Enter the appropriate Occurrence Span code and Date associated beginning (From) and ending (Thru) dates defining a specific event relating to this billing period. Refer to your UB-04 Manual for valid values.
FAC.ZIP		This field identifies the provider's facility ZIP code. The entire nine-digit ZIP code must be entered and should match the facility's master address in the provider enrollment record (usually the facility's physical location).
DCN		The Document Control Number is not required when entering a new bill. Applicable only on adjustments, void/cancel TOB nn7 and nn8.
VALUE CODES-AMOUNTS-	39 – 41	The Value Codes and related dollar amount(s) identify monetary data necessary for the processing of a claim.

Field Name	UB-04 X-Ref.	Description
ANSI (01 – 09)	(a – d)	ANSI is a 5-digit field made up of 2-digit Group Codes and 3-digit Reason (Adjustment) Code. This field is system-filled and will be used for sending ANSI information for the value codes to the Financial System for reporting on the remittance advice. Refer to your UB-04 Manual for valid values.
MSP APP IND		This field identifies to the MSP PAY module whether the system apportions the primary payer's amount and the OTAF amounts (if present). Valid values are: ' ' = Apportion 'N' = Do not apportion This field is not required on claim entry. MSP claims cannot be submitted through DDE.

UB-04 Claim Entry – Page 2

Enter the following information on page two of the UB-04 Claim Entry screen:

- Revenue codes (the system will automatically submit the claim with the revenue codes in ascending order).
- Dollar amounts without decimal points (e.g., for $45.50, type '4550').
- Revenue code 001 should be used in the final revenue code entry and correspond with the totals for Total Charges, Non-covered Charges, Total Units, and Covered Units.
- To delete a revenue code line, type four zeros over the revenue code and press **[ENTER]**, or type '**D**' in first position of field, hit the **[HOME]** key and then press **[ENTER]**.
- To insert a revenue code line, type it at the bottom of the list and press **[ENTER]**; DDE will automatically re-sort the lines. Be sure to adjust the totals on the 001 revenue code line if already entered.
- **[F2]** – a 'jump key' when placed on a revenue code on MAP171D allows you to scroll to the same revenue code line on MAP171D

A total of 13 revenue code lines are available per screen. To enter additional revenue lines, press **[F6]** to page forward and **[F5]** to page back. If you delete or insert a revenue code line, the system will re-sort the lines. There are a total of 450 revenue code lines. Thus, only 449 revenue code lines can be entered on a single claim plus the 001 revenue code line.

INST Claim Entry Screen – Page 2 (MAP1712) – Field descriptions are in the table Following Figure 41.

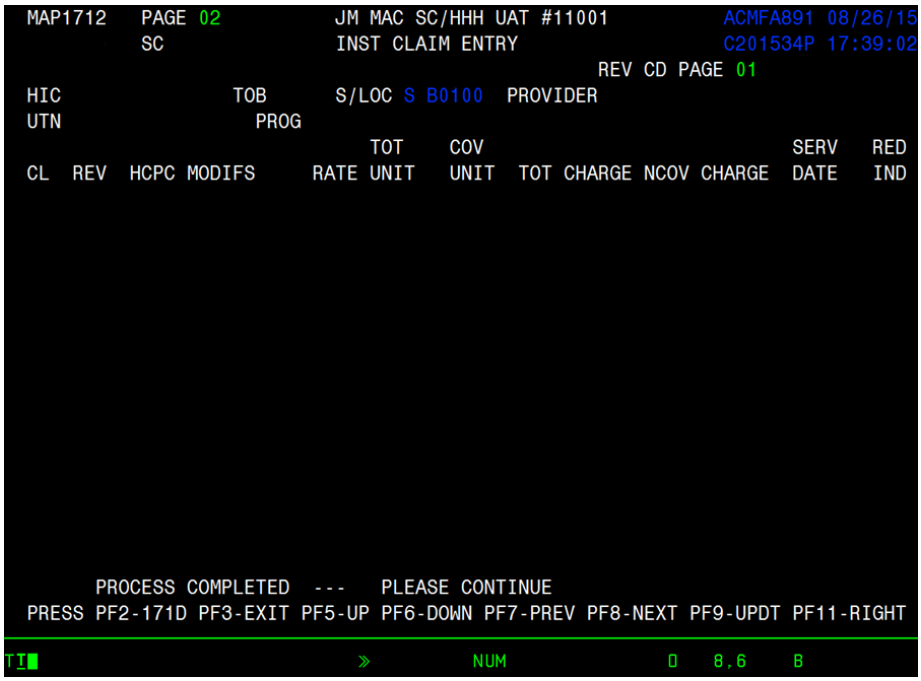


Figure 41 – UB-04 Claim Entry Revenue Screen

Field Name	UB-04 X-Ref.	Description
REV CD PAGE 01		This field identifies the page number for the revenue code lines. A total of 13 revenue code lines can be entered on each page. **[F6]** to move to the next revenue code line page. The page number will change as you move through the revenue code pages.
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system. The default S/LOC is S B0100.
PROVIDER	57	This field displays the provider identification number.
UTN		**Unique Tracking Number (UTN):** This is a 14-digit field that identifies the UTN submitted on the claim in the Medicare Treatment Authorization field. The UTN is submitted on claims that require prior authorization. See figure 47 regarding the Treatment Authorization field.
PROG		**Program Indicator**: This field identifies the Prior Authorization Program ID matching to the item/services submitted on the claim. This is a four-digit alpha-numeric field. The valid format is ANNN or HNNN.
CL		Identifies the claim line number of the Revenue Code. There are 13 revenue code lines per page with a total of 450 revenue code lines possible per claim (this includes the 001 revenue code line). The system will input the revenue code line number when [F9] is pressed. It will be present for update and inquiry.
REV	42	The Revenue Code for a specific accommodation or service that was billed on the claim. Valid values are 0001 through 9999. • List revenue codes in an ascending sequence and do not repeat revenue codes on the same bill if possible.

Field Name	UB-04 X-Ref.	Description
		• To limit line item entries on each bill, report each revenue code only once, except when distinct HCPCS code reporting requires repeating a revenue code (e.g., laboratory services, revenue code 300, repeated with different HCPCS codes), an accommodation revenue code that requires repeating with a different rate, or when mandated per CMS regulations. • Revenue code 001 (total charges and units) should always be the final revenue code entry. • Some codes require CPT/HCPCS codes, units and/or rates.
HCPC	44	Enter the HCPCS code describing the service, if applicable. HCPCS coding must be reported for specific outpatient services including, but not limited to: • Outpatient clinical diagnostic laboratory services billed to Medicare, enter the HCPCS code describing the lab service; • Outpatient hospital bills for Medicare defined surgery procedure; • Outpatient hospital bills for outpatient partial hospitalization; • Radiology and other diagnostic services; • Durable Medicare Equipment (including orthotics and prosthetics); • ESRD drugs, supplies, and laboratory services; • Inpatient Rehabilitation Facility (IRF) PPS claims, this HCPC field contains the submitted HIPPS/CMG code required for IRF PPS claims • Home Health Agency (HHA) claims, this HCPC filed contains the submitted HIPPS code with revenue code 0023; and • Other Provider services in accordance with CMS billing guidelines.
MODIFS	44	A 2-digit numeric or alphanumeric modifier (up to 2 occurrences).
RATE	44	Enter the rate for the revenue code if required.
TOT UNIT	46	Total Units of Service indicates the total units billed. This reflects the units of service as a quantitative measure of service rendered by revenue category.
COV UNIT	46	Covered Units of Service indicates the total covered units. This reflects the units of service as a quantitative measure of service rendered by revenue category.
TOT CHARGE	47	Report the total charge pertaining to the related revenue code for the current billing period as entered in the statement covers period.
NCOV CHARGE	48	Report non-covered charges for the primary payer pertaining to the related revenue code. Submission of bills by providers for all stays, including those for which no payment can be made, is required to enable the Medicare contractor and CMS to maintain utilization records and determine eligibility on subsequent claims. When non-covered charges are present on the bill, remarks are required in UB-04 X-REF 80.
SERV DT	45	The service date is required for every line item where a HCPCS code is required effective April 1, 2000, including claims where the 'from' and 'through' dates are equal. Inpatient Rehabilitation Facility (IRF) PPS claims, this field is not required on the Revenue Code 0024 line. However, if present on the Revenue Code 0024 line, it indicates the date the Provider transmitted the patient assessment. This date, if present, must be equal to or greater than the discharge date (Statement Cover To Date).
RED IND		This field identifies if the payment for the line was paid using the therapy reduced rate. Not required for new claims entry.

UB-04 Claim Entry – Page 2: Additional NPI Lines

This screen displays additional NPI lines and National Drug Code (NDC) fields. This screen can be accessed by pressing [F11] from the revenue code line screen MAP1712.

INST Claim Entry Screen – Page 2 Additional NPI Lines (MAP171E) – Field Descriptions are provided in the table following figure 42.

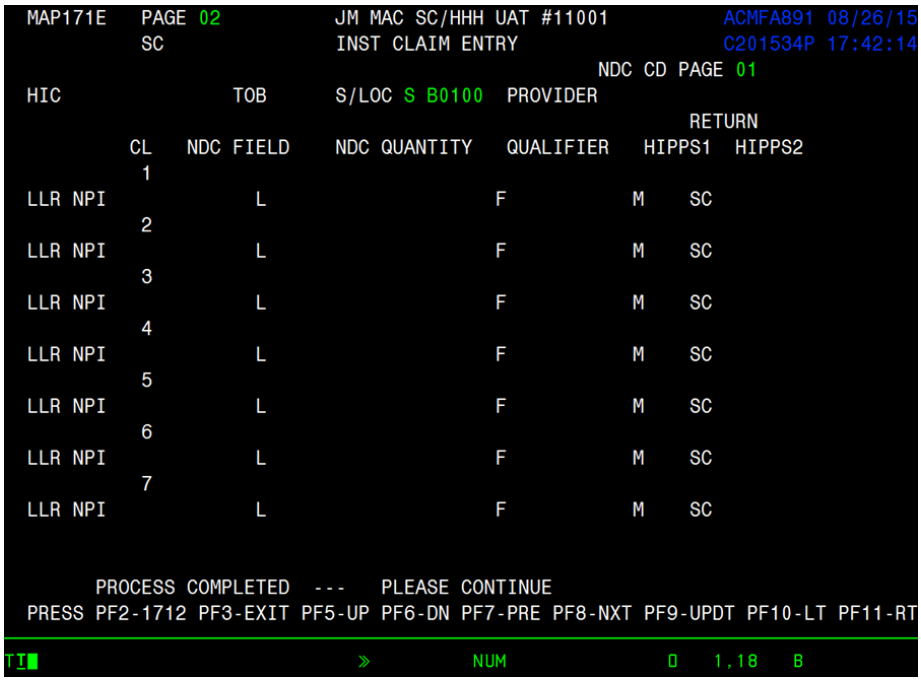


Figure 42 – UB-04 Claim Entry, Page 2, Additional NPI lines

Field Name	UB-04 X-Ref.	Description
NDC CD PAGE 01		There are a total of 33 pages to account for 450 revenue lines. Press [F6] to advance to the next page. The page number will change each time you press [F6].
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
CL 1 - 7		This field identifies the claim line number.
NDC FIELD		This field identifies the National Drug Code (NDC).
NDC QUANTITY		This field identifies the NDC quantity.
QUALIFIER		This field identifies the NDC quantity qualifier.
RETURN HIPPS1		This field identifies the HIPPS codes returned from the QIES Response file. This is a five-digit alphanumeric field.
RETURN HIPPS2		This field identifies the HIPPS code returned from the QIES response file. This is a five-digit alphanumeric field.
LLR NPI		This field identifies the *line level* rendering physician's NPI number.
L		The last name of the rendering physician.
F		The first name of the rendering physician.
M		The middle initial of the rendering physician.
SC		This field identifies the Critical Access Hospital Physician/Non-Physician specialty code.

UB-04 Claim Entry – Page 2: Line Level Reimbursement

This screen displays line item payment information and allows entry of more than two modifiers. Access the MAP171A screen (Figure 43) by pressing **[F11]** twice on Claim Page 2 MAP1712.

INST Claim Entry Claim – Page 2 Line Level Reimbursement (MAP171A) – Field descriptions are provided in the table following Figure 43.

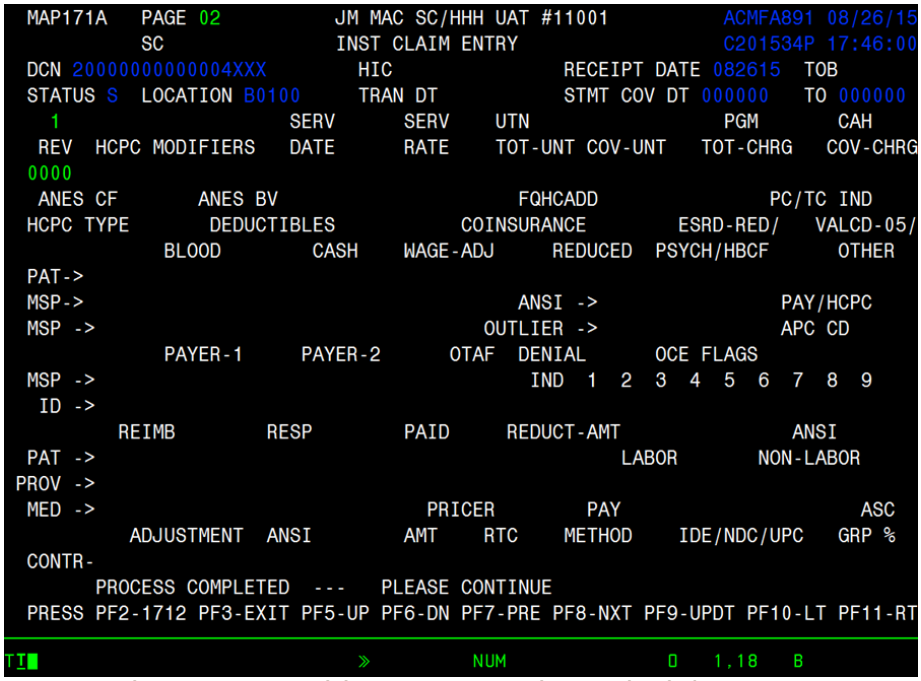


Figure 43 – UB-04 Claim Entry, Page 2, Line Level Reimbursement

Field Name	UB-04 X-Ref.	Description
DCN		The document control number assigned to the claim.
HIC	60	The patient's Medicare number as shown on the Medicare card.
RECEIPT DATE		The date the claim was received into the Medicare claims processing system. Not required for new claims entry.
TOB	4	This field shows the type of bill being submitted.
STATUS		The current status of the claim. New claim entries will display 'S'.
LOCATION		The current location of the claim in the system. New claim entries will display B0100 until [F9] is pressed.
TRAN DT		This field displays the transaction date. Not displayed on new claim entries.
STMT COV DT/TO	6	The statement cover dates entered on MAP1711.
UTN		**Unique Tracking Number (UTN):** This is a 14-digit field that identifies the UTN submitted on the claim in the Medicare Treatment Authorization field. The UTN is submitted on claims that require prior authorization. See figure 47 regarding the Treatment Authorization field.
PROG		**Program Indicator**: This field identifies the Prior Authorization Program ID matching to the item/services submitted on the claim. This is a four-digit alpha-numeric field. The valid format is ANNN or HNNN.

Field Name	UB-04 X-Ref.	Description
CAH		**Critical Access Hospital (CAH) Incentive Indicator**: This field identifies whether a claim line is eligible for a specific type of bonus. This is a one-position alphanumeric field. Valid values are: 1 = HPSA 2 = PSA 3 = HPSA and PSA 4 = HSIP 5 = HPSA and HSIP 6 = PCIP 7 = HPSA and PCIP ' ' = Not applicable NOTE: The system determines the bonus eligibility status of the line based on the Offsite Zip Code field on MAP1713 in Figure 44.
REV	42	The Revenue Code displays a code for a specific accommodation or service that was billed on the claim. This will be the revenue code selected on MAP1712.
HCPC	44	The Healthcare Common Procedure Code identifies certain medical procedures or equipment for special pricing, assigned by CMS.
MODIFIERS	44	This field will contain five 2-character HCPCS modifiers. The two modifiers entered on MAP1712 will be displayed and the user can enter any remaining modifiers.
SERV DATE	45	The date of service (in MMDDYY format) required for many outpatient bills. It will be the same as the line item selected on MAP1712.
SERV RATE	44	Identifies the per-unit cost for a particular line item. This is the rate that was entered on MAP1712.
TOT-UNT	46	Total Units is a quantitative measure of services rendered by revenue category. The total units displayed on this screen are the same as that entered on MAP1712.
COV-UNT	46	Covered Units is a quantitative measure of services rendered by revenue category. The covered units displayed on this screen are the same as that entered on MAP1712.
TOT-CHRG	47	The total charges displayed on this page are the same as that entered on MAP1712.
COV-CHRG	47	This field identifies the covered charges entered on MAP1712.
ANES CF		This field identifies the anesthesia conversion factor.
ANES BV		This field identifies the anesthesia base values.
FQHCADD		**Federally Qualified Health Care (FQHC) Add On**: This field identifies the line level FQHC additional payment amount for a new patient or initial Medicare visit. This is a 13-digit alphanumeric field in 999999999.99 format.
PC/TC IND		This field identifies the PC/TC Indicator that is added to the CORF services Supplemental Fee Schedule.
HCPC TYPE		This field identifies whether the HCPCS originated from the MPFS database files and it paid off the fee rate. This is a one-position alphanumeric field. The value values are: M = Originated from MPFS database files ' ' = Did not originate from the MPFS database files NOTE: 'M' indicates the claim is considered an MPFS claim and is edited based on the zip code of the provider master address record. If it's an 'M' and the plus four flag of the 5-digit zip code record is a '1', then the provider master address must contain a valid 4-digit extension. The carrier and locality on the provider master address record and the carrier and locality of the zip code file must match. Otherwise, the claim receives an edit.

Field Name	UB-04 X-Ref.	Description
DEDUCTIBLES BLOOD		The amount of Medicare Patient Blood Deductible applied to the line item. Blood deductible will be applied at the line level on revenue codes 380, 381 and 382.
DEDUCTIBLES CASH		The amount of Medicare patient cash deductible applied to the line item. This field is system filled.
COINSURANCE WAGE-ADJ		The amount of Patient Wage Adjustment Coinsurance applicable to the line based on the particular service rendered. The revenue and HCPCS code submitted define the service. For services subject to outpatient PPS (OPPS) in hospitals (TOB 12X, 13X and 14X) and in community mental health centers (TOB 76X), the applicable coinsurance is wage adjusted. Therefore, this field will have either a zero (for the services without applicable coinsurance) or a regular coinsurance amount (calculated on either charges or a fee schedule), unless the service is subject to OPPS. If the service is subject to OPPS, the national coinsurance amount will be wage adjusted, based on the MSA where the Provider is located or assigned as the result of a reclassification. CMS supplies the national coinsurance amount to the FIs, as well as the MSA by Provider. This field is system filled.
COINSURANCE REDUCED		For all services subject to OPPS (TOB 12X, 13X, 14X, and 76X) the amount of Patient Reduced Coinsurance applicable to the line for a particular coinsurance amount. Providers are only permitted to reduce the coinsurance amount due from the beneficiary for services paid under OPPS, and the reduced amount cannot be lower than 20% of the payment rate for the line. If the provider does not elect to reduce the coinsurance amount, the field will contain zeros.
ESRD-RED/PSYCH/ HBCF		The Patient End Stage Renal Disease Reduction/Psychiatric Reduction/ Hemophilia Blood Clotting Factor will notate one of three values: ▪ ESRD reduction refers to the ESRD network reduction amount and is found on Claim Page 1 in Value Code 71. ▪ Psychiatric reduction applies to line items that have a 'P' pricing indicator. The amount represents the psychiatric coinsurance amount (37.5% of covered charges). ▪ Hemophilia Blood Clotting Factor represents an additional payment to the DRG payment for hemophilia. The additional payment is based on the applicable HCPC. This payment add-on applies to inpatient claims.
VALCD-05/ OTHER		If Value Code 05 is present on the claim, this field will contain the portion of the value code 05 amount that is applicable to this line item. The value code 05 amount is first applied to revenue codes 96n, 97n and 98n, and then applied to revenue code lines in numeric order that are subject to deductible and/or coinsurance.
PAT		This field identifies the amount of the patient's blood and cash deductibles and the coinsurance amounts.
MSP		This field identifies the Medicare Secondary Payer deductible (blood and cash) and coinsurance (wage adjusted and reduced) amounts calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.
MSP		This field identifies additional Medicare Secondary Payer deductible (blood and cash) and coinsurance (wage adjusted and reduced) amounts calculated within the MSPPAY module and apportioned upon return from the MSPPAY module. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.

Field Name	UB-04 X-Ref.	Description
ANSI		This 2-character Group Code and 3-character Reason (Adjustment) Code is used to send ANSI information to the Financial System for reporting on the remittance advice for the ESRD Reduction/Psychiatric Coinsurance/ Hemophilia Blood Clotting Factor.
PAY/HCPC APC CD		**HCPC Ambulatory Patient Classification Code –** Identifies the APC (Payment Ambulatory Patient Classification Code) group number by line item. Payment for services under the OPPS is calculated based on grouping outpatient services into APC groups. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. Both APC codes appear on the claims file, but only one appears on the screen. If their values are different, this indicates a partial hospitalization item. In this case the payment APC code is displayed. When the item is not a partial hospitalization, the HCPC APC code is displayed. This data is read from the claims file. If an APC is not found, the value will default to '00000'. Claim page 31 displays the HIPPS code if different from what is billed. If medical changes the code, the new HIPPS code is displayed in the PAY/HCPC APC CD field and a value of 'M' is in the OCE flag 1 field. When a value of 'M' is in the OCE flag 1 field, the MR IND field is automatically populated with a 'Y'. If Pricer changes the code, the new HHRG is displayed in the PAY/HCPC APC CD field and a value of 'P' is in the OCE flag 1 field. If the HIPPS code was not changed, fields PAY/HCPC APC CD and OCE flag 1 are blank. For Home Health PPS claims, claim page 31 displays the HIPPS code if different from what is billed. If the Inpatient Rehabilitation Facility (IRF) PPS Pricer returns a HIPPS/CMG code different from what was billed, the new HIPPS/CMG code is displayed on the revenue code 0024 line in the PAY/HCPC/APC CD field and a value of 'I' is displayed in the OCE FLAG 1 field. If the IRF PPS Pricer does not change the HIPPS/CMG code, these fields are blank.
OUTLIER		This field identifies the outlier amount paid, if applicable.
PAYER-1		The amount entered by the user (if available) or apportioned by MSPPAY as payment from the primary (Medicare Secondary Payer 1) payer. The MSPPAY module based on amount in the value code for the primary payer apportions this amount. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.
PAYER-2		The amount entered by the user (if available) or apportioned by MSPPAY as payment from the secondary (Medicare Secondary Payer 2) payer. The MSPPAY module based on amount in the value code for the secondary payer apportions this amount. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.
OTAF		The Obligated to Accept in Full field contains the line item apportioned amount entered by the user (if available) or apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full. This field will be populated when value code 44 is present. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.
DENIAL IND		The Medicare Secondary Payer Denial Indicator field provides the user an opportunity to tell the MSPPAY module that an insurer primary to Medicare has denied this line item. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE. Valid values are: ' ' = Blank D = Denied

Field Name	UB-04 X-Ref.	Description
OCE FLAGS		The Outpatient Code Editor flags identify eight fields that are returned by the OCE module via the APC return buffer. OCE flags are: Flag 1 = Service Flag 2 = Payment Flag 3 = Discounting Factor Flag 4 = Line Item Denial or Rejection Flag 5 = Packing Flag 6 = Payment Adjustment Flag 7 = Type of Bill Inclusion Flag 8 = Line Item Action
MSP		This field identifies the MSP Payer 1 and Payer 2 amounts entered based on the value codes entered. Not required on new claims entry. Not displayed on new claims. MSP claims cannot be submitted through DDE.
ID		This Medicare Secondary Payer Payer-1 ID code identifies the specific payer. If Medicare is primary, this field will be blank or populated with a 'Z' for Medicare. Valid values are: 1 = Medicaid 2 = Blue Cross 3 = Other 4 = None A = Working Aged B = End Stage Renal Disease (ESRD) Beneficiary in 12-month coordination period with an employer group health plan C = Conditional Payment D = Auto No-Fault E = Workers' Compensation F = Public Health Service or other Federal Agency G = Disabled H = Black Lung I = Veterans Administration L = Liability
REIMB		The Patient Reimbursement amount is determined by the system to be paid to the patient on the basis of the amount entered by the Provider on claim page 3, in the 'Due from Pat' field. This amount is the calculated line item amount.
RESP		Patient Responsibility identifies the amount for which the individual receiving services is responsible. The amount is calculated as follows • If the Payer-1 indicator is 'C' or 'Z', then the amount will equal Cash Deductible + Coinsurance + Blood Deductible. • If the Payer-1 indicator is not 'C' or Z', then the amount will equal MSP Blood + MSP Cash Deductible + MSP Coinsurance. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.
PAID		This is the patient paid amount calculated by the system. This amount is the lower of Patient Reimbursement + Patient Responsibility or the remaining Patient Paid (after the preceding lines have reduced the amount entered on Claim Page 3).
REDUCT - AMT		This field identifies the 10% reduction amount by a processed 121 re-billed demonstration claim that paid 90% of allowable services identified by including Claim Adjustment Reason Codes (CARC) '45' to report the adjustment due to difference in billed charged and allowed amount, and CARC '132' to report adjustments due to a 10% reduction in conjunction with Group Code of 'CO'. This is a ten-position alphanumeric field in 99999999.99- format.
ANSI		This field identifies the group code and the CARC code for the reduction amount above. The group code is a one-digit alphanumeric field.

Field Name	UB-04 X-Ref.	Description
PAT		The patient's reimbursement, responsibility, paid and reduction amounts.
PROV		The provider's reimbursement, responsibility, paid and reduction amounts.
MED		The Medicare reimbursement amount
LABOR		Identifies the labor amount of the payment as calculated by the pricer.
NON-LABOR		Identifies the non-labor amount of the payment as calculated by the pricer.
MED		This is the total Medicare Reimbursement for the line item. It will be the sum of the Patient Reimbursement and the Provider Reimbursement.
ADJUSTMENT		The following calculation will be performed to obtain the total Contractual Adjustment: (Submitted Charges) – (Deductible) – (Wage Adjusted Coinsurance) – (Blood Deductible) – (Value Code 71) – (Psychiatric Reduction) – (Value Code 05/Other) – (Reimbursement Amount). For MSP claims, the MSP deductible, MSP blood deductible and MSP coinsurance are used in the above calculation in place of the deductible, blood deductible and coinsurance amounts. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE.
ANSI		The ANSI Group-ANSI Adjustment Code consists of a 2-character group code and a 3-character reason (adjustment) code. It is used to send ANSI information to the Financial System for reporting on the remittance advice.
PRICER AMT		The Pricer Amount provides the line item reimbursement received from a Pricer.
PRICER RTC		Identifies the Pricer Return Code from OPPS. Valid values include: *Describes how the bill was priced* 00 = Priced standard DRG payment 01 = Paid as day outlier/send to PRO for post payment review 02 = Paid as cost outlier/send to PRO for post payment review 03 = Paid as per diem/not potentially eligible for cost outlier 04 = Standard DRG, but covered days indicate day outlier but day or cost outlier status was ignored 05 = Pay per diem days plus cost outlier for transfers with an approved cost outlier 06 = Pay per diem days only for transfers without an approved outlier 10 = Bad state code for SNF Rug Demo or Post-Acute Transfer for Inpatient PPS Pricer DRG is 209, 210 or 211 12 = Post-acute transfer with specific DRGs of 14,113,236, 263, 264, 429, 483 14 = Paid normal DRG payment with per diem days = or > average length of stay 16 = Paid as a Cost Outlier with per diem days = or > average length of stay 20 = Bad revenue code for SNF Rug Demo or invalid HIPPS code for SNF PPS Pricer 30 = Bad Metropolitan Statistical Area (MSA) Code *Describes why the bill was not priced* 50 = No Provider specific information found 52 = Invalid MSA in Provider file 53 = Waiver State – no calculated by PPS 54 = DRG not '001'-'468' or '471'-'910' 55 = Discharge date is earlier than Provider's PPS start date 56 = Invalid length of stay 57 = Review code not '00' – '07' 58 = Charges not numeric 59 = Possible day outlier candidate

Field Name	UB-04 X-Ref.	Description
		60 = Review code '01' and length of stay indicates day outlier. Bill is not eligible as cost outlier 61 = Lifetime reserve days not numeric 62 = Invalid number of covered days (e.g., more than approved length of stay, non-numeric or lifetime reserve days greater than covered days) 63 = Review code of '00' or'03,' and bill is cost outlier candidate 64 = Disproportionate share percentage and bed size conflict on Provider specific file 98 = Cannot process bill older than 10/01/87
PAY METHOD		Identifies the method of payment (i.e., OPPS, LAB fee schedule, etc.) returned from OCE. Valid values include: 1 = Paid standard OPPS amount (service indicators 'S,' 'T,' 'V,' 'X,' or 'P') 2 = Services not paid under OPPS (service indicator 'A,' or no HCPCS code and certain revenue codes) 3 = Not paid (service indicators 'C' or 'E') 4 = Acquisition cost paid (service indicator 'F') 5 = Designated current drug or biological payment adjustment (service indicator 'G') 6 = Designated new device payment adjustment (service indicator 'H') 7 = Designated new drug or new biological payment adjustment (service indicator 'J') 8 = Not used at present 9 = No separate payment included in line items with APCS (service indicator 'N,' or no HCPCS code and certain revenue codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization program services)
IDE/NDC/UPC		This field contains IDE, NDC, or UPC. IDE- Investigational Device Exemption NDC Reserved for future use UPC Reserved for future use
ASC GRP		Identifies the Ambulatory Surgical Center Group code for the indicated revenue code.
ASC %		Identifies the Ambulatory Surgical Center Percentage used by the ASC Pricer in its calculation for the indicated revenue code.
CONTR		This field identifies the contractor amounts.

UB-04 Claim Entry – Page 2: Additional Detail

This page is a copy of core claim MAP171D. Providers may only view this page. No additions, modifications or deletions may be made here. This page is accessed by pressing [F2] or [F11 three times] on claim page 2 (MAP1712).

INST Claim Entry Screen – Page 2 Additional Details (MAP171D) Field descriptions for this screen are provided in the table following Figure 44.

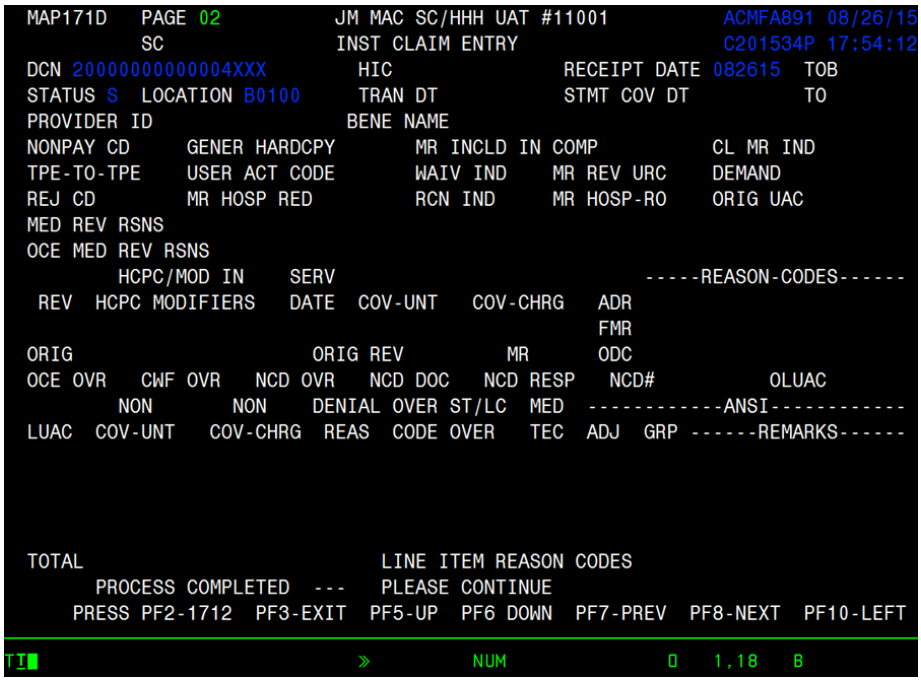


Figure 44 – UB-04 Claim Entry, Page 2, Additional Detail

Field Name	UB-04 X-Ref.	Description
DCN		The document control number assigned to the claim.
HIC	60	The patient's Medicare number as shown on the Medicare card.
RECEIPT DATE		The date the claim was received into the Medicare claims processing system. Not required for new claims entry.
TOB	4	This field shows the type of bill being submitted.
STATUS		The current status of the claim. New claim entries will display 'S'.
LOCATION		The current location of the claim in the system. New claim entries will display B0100 until [F9] is pressed.
TRAN DT		This field displays the transaction date. Not displayed on new claim entries.
STMT COV DT/TO	6	The statement cover dates entered on MAP1711.
PROVIDER ID	57	Identifies the identification number of the Provider submitting the claim.
BENE NAME	8a	The name of the Beneficiary (20 positions for the last name and 10 positions for the first name).
NON PAY CD		The Non-Pay Code identifies the reason for Medicare's decision not to make payment. Valid values include: B = Benefits exhausted C = Non-Covered Care (discontinued) E = First Claim Development (Contractor 11107) F = Trauma Code Development (Contractor 11108) G = Secondary Claims Investigation (Contractor 11109) H = Self Reports (Contractor 11110) J = 411.25 (Contractor 11111) K = Insurer Voluntary Reporting (Contractor 11106) N = All other reasons for non-payment P = Payment requested Q = MSP Voluntary Agreements (Contractor 88888) Q = Employer Voluntary Reporting (Contractor 11105)

Field Name	UB-04 X-Ref.	Description
		R = Spell of illness benefits refused, certification refused, failure to submit evidence, Provider responsible for not filing timely or Waiver of Liability T = MSP Initial Enrollment Questionnaire (Contractor 99999 or 11101) U = MSP HMO Cell Rate Adjustment (Contractor 55555) U = HMO/Rate Cell (Contractor 11103) V = MSP Litigation Settlement (Contractor 33333) V = Litigation Settlement (Contractor 11104) W = Workers Compensation X = MSP cost avoided Y = IRS/SSA Data Match Project MSP Cost Avoided (Contractor 77777) Y = IRS/SSA CMS Data Match Project Cost Avoided (Contractor 11102) Z = System set for type of bills 322 and 332, containing dates of service 10/01/00 or greater and submitted as an MSP primary claim. This code allows the FISS to process the claim to CWF and allows CWF to accept the claim as billed. 00 = COB Contractor (Contractor 11100) 12 = Blue Cross – Blue Shield Voluntary Agreements (Contractor 11112) 13 = Office of Personnel Management (OPM) Data Match (Contractor 11113) 14 = Workers' Compensation (WC) Data Match (Contractor 11114)
GENER HARDCPY		Instructs the system to generate a specific type of hard copy document. Valid values include: 2 = Medical ADR 3 = Non-Medical ADR 4 = MSP ADR 5 = MSP Cost Avoidance ADR 7 = ADR to Beneficiary 8 = MSN (Line Item) or Partial Benefit Denial Letter 9 = MSN (Claim Level) or Benefit Denial Letter
MR INCLD IN COMP		The Composite Medical Review Included in the Composite Rate field that identifies (for ESRD bills) if the claim has been denied because the service should have been included in the Comp Rate. Valid value is 'Y' (the claim has been denied). **Note**: ESRD claims are no longer paid based on a composite rate.
CL MR IND		This indicator identifies if all services on the claim received Complex Manual Medical Review. The value entered in this field automatically populates the MR IND field for all revenue code lines on the claim. Valid values are: ' ' = The services did not receive manual medical review (default) Y = Medical records received. This service received complex manual medical review N = Medical records were not received. This service received routine manual medical review

<table>
<tr><th>Field Name</th><th>UB-04 X-Ref.</th><th>Description</th></tr>
<tr><td>TPE-TO-TPE</td><td></td><td>Identifies the tape-to-tape flag (if applicable). The flag indicators across the top of the chart instruct the system to either perform or skip each of the four functions listed on the left of the chart below. The first indicator column represents a blank. If this field is blank, all functions are performed (as indicated on this chart).
<table>
<tr><th>Function</th><th>‘ ’</th><th>Q</th><th>R</th><th>S</th><th>T</th><th>U</th><th>V</th><th>W</th><th>X</th><th>Y</th><th>Z</th></tr>
<tr><td>Transmit to CWF</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>N</td></tr>
<tr><td>Print on Remittance Advice</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>N</td><td>Y</td><td>Y</td><td>N</td></tr>
<tr><td>Include on PS&R</td><td>Y</td><td>N</td><td>N</td><td>N</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>N</td></tr>
<tr><td>Include on Workload</td><td>Y</td><td>Y</td><td>N</td><td>Y</td><td>Y</td><td>N</td><td>N</td><td>Y</td><td>Y</td><td>N</td><td>N</td></tr>
</table></td></tr>
<tr><td>USER ACT CODE</td><td></td><td>The User Action Code is used for medical review and reconsideration only. The first position is the User Action Code and the second position is the Reconsideration Code. The reconsideration user action code will always be ‘R’. When a reconsideration is performed on the claim, the user should enter a ‘R’ in the second position of the claim user action code, or in the line user action code field. This tells the system that reconsideration has been performed. Valid values include:

Medical Review
A = Pay per waiver - full technical.
B = Pay per waiver - full medical.
C = Provider liability - full medical - subject to waiver provisions.
D = Beneficiary liability - full - subject to waiver provisions.
E = Pay claim - line full.
F = Pay claim - partial - claim must be updated to reflect liability.
G = Provider liability - full technical - subject to waiver provisions.
H = Full or partial denial with multiple liabilities. Claim must be updated to reflect liability.
I = Full Provider liability - medical - not subject to waiver provisions.
J = Full Provider liability - technical - not subject to waiver provisions.
K = Full Provider liability - not subject to waiver provisions.
M = Pay per waiver - line or partial line.
N = Provider liability - line or partial line.
O = Beneficiary liability - line or partial line.
P = Open biopsy changed to closed biopsy.
Q = Release with no medical review performed.
R = CWF (Common Working File) denied but medical review was performed.
Z = Force claim to be re-edited by Medical Policy.

Special Screening
5 = Generates systematically from the reason code file to identify claims for which special processing is required.
7 = Force claim to be re-edited by Medical Policy edits in the 5XXXX range but not the 7XXXX range.
8 = A claim was suspended via an OCE MED review reason.
9 = Claim has been identified as ‘First Claim Review.’</td></tr>
<tr><td>WAIV IND</td><td></td><td>Identifies whether the Provider has their presumptive waiver status. Valid values are:
Y = The Provider does have their waiver status
N = The Provider does not have their waiver status</td></tr>
<tr><td>MR REV URC</td><td></td><td>The Medical Review Utilization Review Committee Reversal field identifies whether an SNF URC Claim has been reversed. This indicator can be used for a partial or a full reversal. Valid values are:</td></tr>
</table>

Field Name	UB-04 X-Ref.	Description
		P = Partial reversal F = Full reversal, the system reverses all charges and days
DEMAND		The Medical Review Demand Reversal field identifies that an SNF demand claim has been reversed. Valid values are: P = Partial reversal, it is the operator's responsibility to reverse the charges and days to reflect the reversal. F = Full reversal, the system reverses all charges and days.
REJ CD		The Reject Code identifies the reason code for which the claim is being denied.
MR HOSP RED		The Medical Review Hospice Reduced field identifies (for hospice bills) the line item(s) that have been reduced to a lesser charge by medical review. Valid values are: ' ' = Not reduced Y = Reduced
RCN IND		The Reconsideration Indicator is used only for home health claims. Valid values include: A = Finalized count affirmed B = Finalized no adjustment count (pay per waiver) R = Finalized count reversal (adjustment) U = Reconsideration
MR HOSP-RO		The Medical Review Regional Office Referred field identifies (for RO Hospice bills) if the claim has been referred to the Regional Office for questionable revocation. Valid values are: ' ' = Not referred Y = Referred
ORIG UAC		**Original User Action Code**: This field identifies the original user action code. It is populated/updated when the claim level user action code is populated/updated. This is a two-digit alphanumeric field.
MED REV RSNS		The Medical Review Reasons field identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field displays medical review reasons specific to claim level. The system determines this by a 'C' in the claim/line indicator on the reason code file. The medical review reasons must contain a '5' in the first position.
OCE MED REV RSNS		The OCE Medical Review field displays the edit returned from the OPPS version of OCE. Valid values include: 11 = Non-covered service submitted for review (condition code 20) 12 = Questionable covered service 30 = Insufficient services on day of partialization 31 = Partial hospitalization on same day as electro convulsive therapy or type T procedure 32 = Partial hospitalization claim spans 3 or less days with insufficient services, or electro convulsive therapy or significant procedure on at least one of the days 33 = Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services
UNTITLED		This Claim Line Number field identifies the line number of the revenue code. The line number is located above the revenue code on this map. To move to another revenue code, enter the new line number and press [ENTER].
REV	47	Identifies the Revenue Code for a specific accommodation or service that was billed on the claim. This information was entered on MAP1712. Valid values are 01 to 9999. To move to the next Revenue Code with a line level reason code, position the cursor in the page number field and press [F2].

Field Name	UB-04 X-Ref.	Description
HCPC/MOD IN	44	Identifies if the HCPC Code, Modifier or REV Code was changed. Valid values are: U = Up coding D = Down coding ' ' = Blank A 'U' or 'D' in this field opens the REV Code and HCPC/Mod fields to accept the changed code. Enter 'U' or 'D', tab down to the REV Code and HCPC/ MOD fields. After the new code is entered, the original Rev Code and HCPC/MOD fields move down to the ORIG REV or ORIG HCPC/MOD field.
HCPC	44	Identifies the HCPC code that further defines the revenue code being submitted. The information on this field was entered on MAP1712.
MODIFIERS	44	Identifies the HCPCS modifier codes for claim processing. This field may contain five-2 position modifiers.
SERV DATE	45	The line item date of service, in MMDDYY format, and is required for many outpatient bills. This information was entered on MAP1712.
COV-UNT	46	The number of covered units associated with the revenue code line item being denied.
COV-CHRG	47	The number of covered charges associated with the revenue code line item being denied.
ADR		Identifies the Additional Development Reason Codes that are present on the screen and allows the user to manually enter up to four occurrences to be used when an ADR letter is to be sent. The system reads the ADR code narrative to print the letter. The letter prints the reason code narrative as they appear on each revenue code line.
FMR		The Focused Medical Review Suspense Codes identify when a claim is edited in the system, based on a parameter in the Medical Policy Parameter file. The system generates the Medical Review code for the corresponding line item on the second page of the Denial/Non-Covered/Charges screen. The system assigns the same Focused Medical Review ID edits on lines that are duplicated for multiple denial reasons. The user may enter or overlay any existing Medical Review suspense codes. Claim level suspense codes should not apply to the line level. The Medical Policy reasons are defined by a '5' or '7' in the first position of the reason code.
ORIG		Identifies the original HCPC billed and modifiers billed, accommodating a 5-digit HCPC and up to 5 2-digit modifiers.
ORIG REV		Identifies the Original Revenue Code billed.
MR		This field indicates if the service received complex manual medical review. The valid values are: ' ' The services did not receive manual medical review (default value) 'Y' Medical records received. This service received complex manual medical review 'N' Medical records were not received. This service received routine manual medial review.
ODC		This field identifies original denial reason codes.
OCE OVR		The OCE Override is used to override the way the OCE module controls the line item. Valid values include: 0 = OCE line item denial or rejection is not ignored 1 = OCE line item denial or rejection is ignored 2 = External line item denial. Line item is denied even if no OCE edits 3 = External line item rejection. Line item is rejected even if no OCE edits
CWF OVR		The CWF Home Health Override field overrides the way the OCE module controls the line item.

Field Name	UB-04 X-Ref.	Description
NCD OVR		This Override Indicator identifies whether the line has been reviewed for medical necessity and should bypass the National Coverage Determination (NCD) edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. Valid values are: ' ' = Default value. The NCD edits are not bypassed. A blank in this field is set on all lines for resubmitted RTP'd claim. Y = The line has been reviewed for medical necessity and bypasses the NCD edits. D = The line has no covered charges and bypasses the NCD edits.
NCD DOC		The National Coverage Determination Documentation Indicator identifies whether the documentation was received for the necessary medical service. This indicator will not be reset on resubmitted RTP'd claims. Valid values are: Y = The documentation supporting the medical necessity was received. N = Default Value. The documentation supporting the medical necessity was not received.
NCD RESP		The National Coverage Determination Response Code that is returned from the NCD edits. Valid values include: ' ' = Set to space for all lines on resubmitted RTP'D claims, (default value.) 0 = The HCPCS/Diagnosis code matched the NCD edit table 'pass' criteria. The line continues through the system's internal local medical necessity edits. 1 = The line continues through the system's internal local medical necessity edits, because: the HCPCS code was not applicable to the NCD edit table process, the date of service was not within the range of the effective dates for the codes, the override indicator is set to 'Y' or 'D', or the HCPCS code field is blank. 2 = None of the diagnoses supported the medical necessity of the claim (list 3 codes), but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. 3 = The HCPCS/Diagnosis code matched the NCD edit table list ICD-9-CM deny codes (list 2 codes). The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to non-coverage by statute. 4 = None of the diagnosis codes on the claim support the medical necessity for the procedure (list 3 codes) and no additional documentation is provided. This line suspends as not medically necessary and will be denied. 5 = Diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and the FI will RTP the claim.
NCD #		National Coverage Determination Number: This field identifies the NCD number associated with the beneficiaries claim denial.
OLUAC		Identifies the original line user action code. It is only populated when there is a line user action code and a corresponding denial reason code in the Benefits Savings portion of claim page 32.
LUAC		The Line User Action Code identifies the cause of denial for the revenue line and a reconsideration code. The denial code (first position) must be present in the system and pre-defined in order to capture the correct denial reason. The values are equal to the values listed for User Action Codes. The reconsideration code (second position) has a value equal to 'R', indicating to the system that reconsideration has been performed.

Field Name	UB-04 X-Ref.	Description
		For the Revenue Code Total Line 0001, the system generates a value in the first two line occurrences of the LUAC field. These values indicate the type of total amount displayed on the total non-covered units and non-covered charges for the revenue code line 0001, only on MAP171D. These values do not apply to this field for any other revenue code line other than 0001. Valid values are: 1 = LUAC lines present on MAP171D 2 = Non-LUAC lines present on MAP171D
NON COV-UNT		Non-Covered Units identifies the number of days/visits that are being denied. Denied days/visits are required for those revenue codes that require units on Revenue Code file. The first line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered units on the revenue code line 0001 identifies the total non-covered units for all lines not containing a LUAC on MAP171D.
NON COV-CHRG	48	Non-Covered Charges identifies the total number of denied/rejected/ non-covered charges for each line item being denied. The first line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines containing a LUAC on MAP171D. The second line occurrence of non-covered charges on the revenue code line 0001 identifies the total non-covered charges for all lines not containing a LUAC on MAP171D.
DENIAL REAS		The denial reason for the revenue code line. The denial code must be present in the system and pre-defined in order to capture the correct denial reason.
OVER CODE		The override code allows the operator to manually override the system generated ANSI codes taken from the Denial Reason Code file. Valid values are: ' ' = Default to system generated A = Override system generated ANSI Codes
ST/LC OVER		The Status/Location Override identifies the override of the reason code file status when a line item has been suspended. Valid values are: ' ' = Process claim with no override code D = Denied, for the reason code on the line R = Rejected, for the reason code on the line
MED TEC		Medical Technical Denial Indicator - This field identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. Valid values include: A = Home Health only - not intermittent care - technical and waiver was applied B = Home Health only - not homebound - technical and waiver was applied C = Home Health only - lack of physicians orders - technical deletion and waiver was not applied D = Home Health only - Records not submitted after the request - technical deletion and waiver was not applied M = Medical denial and waiver was applied S = Medical denial and waiver was not applied T = Technical denial and waiver was applied

Field Name	UB-04 X-Ref.	Description
		U = Technical denial and waiver was not applied
ANSI ADJ		The data for this ANSI Adjustment Reason Code field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the Reason Code file to assign the ANSI code to the denial screen. This code will occur once for each line item.
ANSI GRP		The data for this ANSI Group Code field is from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off of the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.
ANSI REMARKS		The data for this ANSI Remarks Code field is taken from the ANSI file housed as the second page in the Reason Code file. The ANSI codes that appear on the line item can be replaced with a new code and the system processes the denial with the entered code. The ANSI code is built off the denial code used for each line item. Each denial code must be present on the reason code file to assign the ANSI code to the denial screen. This code will occur a maximum of four times.
TOTAL		The total of all revenue code non-covered units and charges present on MAP171D.
LINE ITEM REASON CODES		The Line Item Reason Codes assigned out of the system for suspending the line item. There are a maximum of four (4) FISS reason codes that can be assigned to the line level.

UB-04 Claim Entry – Page 3

Enter the following information onto Page 3 of the Claim Entry screen (Figure 45):

- Payer Information
- Diagnoses Codes
- Attending Physician (UPIN, first and last name)

INST Claim Entry Screen – Page 3 (MAP1713) - Field descriptions are provided in the table following Figure 45.

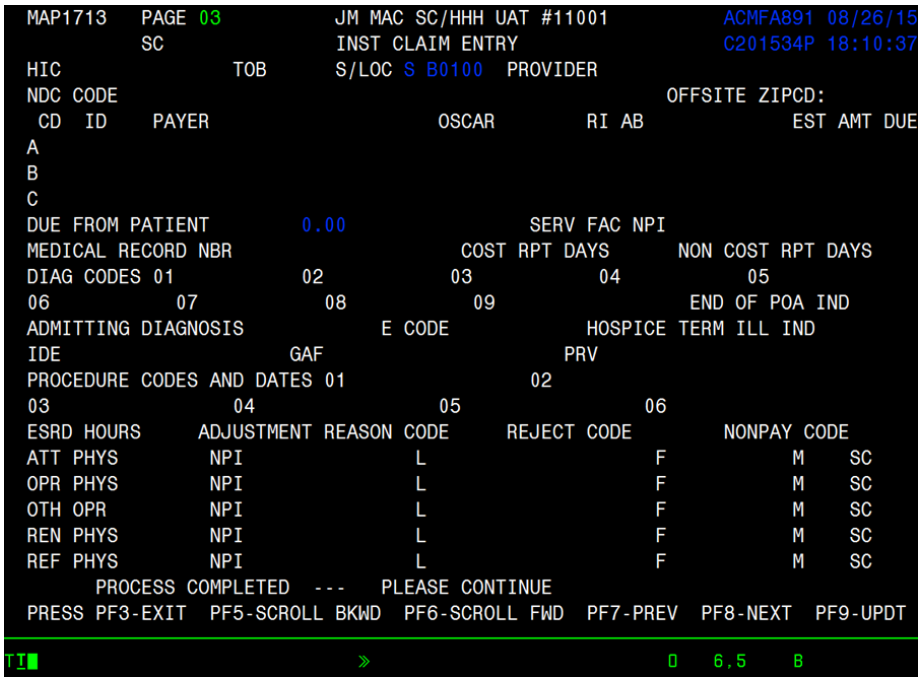


Figure 45 – UB-04 Claim Entry, Page 3

Field Name	UB-04 X-Ref.	Description
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
NDC CODE		This field identifies the National Drug Code (NDC).
OFFSITE ZIPCD		This field identifies offsite Clinic/Outpatient department zip codes. It determines the claim line HPSA/PSA bonus eligibility. NOTE: When a zip code is present, the system uses the zip code for processing, not the zip code for the base provider (CAH). Indicating that one of the off-site clinics/outpatient departments submitted the claim for payment and not the base provider (CAH).
CD	50 A, B, C	Use the following list of Primary Payer Codes when submitting electronic claims for payer identification. The following codes are for Medicare requirements only. Other payers require codes not reflected. Not displayed on new claims. MSP claims cannot be submitted or corrected in DDE. Valid values are: 1 = Medicaid 2 = Blue Cross 3 = Other 4 = None A = Working-age - Employer Group Health Plan (EGHP) B = End Stage Renal Disease (ESRD) beneficiary in 30-month coordinated period with an Employer Group Health Plan C = Conditional payment

Field Name	UB-04 X-Ref.	Description
		D = Automobile no-fault E = Workers' compensation F = Public Health Service (PHS) or other federal agency G = Disabled - Large Group Health Plan (LGHP) H = Black lung (federal black lung program) I = Veteran's administration L = Liability Z = Medicare A
ID		Not required.
PAYER	50 A, B, C	Payer Identification lines: (A) Primary Payer – If Medicare is the primary payer, enter '**Medicare**' on line A. Enter Medicare indicates that the hospital developed for other insurance and determined that Medicare is the primary payer. If there are payer(s) of higher priority than Medicare, the claim must be submitted by another electronic software. MSP claims cannot be submitted or corrected in DDE.
OSCAR	51 A, B, C	This field will auto-populate with the Oscar Number assigned to the provider.
RI	52 A, B, C	The Release of Information Certification Indicator indicates whether the provider has on file, a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.
AB	53 A, B, C	The Assignment of Benefits Certification Indicator shows whether the provider has a signed form authorizing the third party payer to pay the provider.
EST AMT DUE	55 A, B, C	Not applicable.
DUE FROM PATIENT		The Due From Patient field is for outpatient services only. Enter the amount the provider has received from the patient toward payment.
SERV FAC NPI		**Service Facility National Provider Identifier (NPI)**. This field is used to enter the facility NPI of where the services were provided when other than the billing provider. This is a ten-digit field.
MEDICAL RECORD NBR	3b	Alphanumeric field used to enter patient's Medical Record Number.
COST RPT DAYS		The Cost Report Days identify the number of days claimable as Medicare patient days for inpatient and SNF types of bills (11X, 41X, 18X, 21X, 28X, and 51X) on the cost report. The system calculates this field and inserts the applicable data.
NON COST RPT DAYS		Identifies the number of Non-Cost Report Days not claimable as Medicare patient days for inpatient and SNF types of bills (11n, 18n, 21n, 28n, 41n, and 51n) on the cost report.
DIAGNOSIS CODE (01 – 09)	67, A - Q	Used to enter the full Diagnosis Codes for the principal diagnosis code and up to eight additional conditions coexisting at the time of admission which developed subsequently, and which had an effect upon the treatment given or the length of stay.
END OF POA INDICATOR	67	This field identifies the last character of the Present On Admission (POA) indicator, effective with discharges on or after 01/01/08. The valid values are: 'Z' = The end of POA indicators for principal and, if applicable, other diagnosis 'X' = The end of POA indicators for principal and, if applicable, other diagnosis in special processing situations that may be identified by CMS in the future ' ' = Not acute care, POA's do not apply

Field Name	UB-04 X-Ref.	Description
ADMITTING DIAGNOSIS	69	In the Admitting Diagnosis field, for inpatients, enter the full code for the principal diagnosis relating to condition established after study to be chiefly responsible for the admission.
E CODE	68	The External Cause of Injury Code field is used for E-codes should be reported in second diagnosis field Form Locator 68.
HOSPICE TERM ILL IND		Not required.
IDE		Identifies the Investigational Device Exemption (IDE) authorization number assigned by the FDA.
GAF		**Geographic Adjustment Factors**: This field identifies the GAF for state, carrier and locality (at the claim level.) This is a 13-digit alphanumeric field in 999999999.99 format.
PRV		**Patient Reason for** Visit: This field identifies the ICD-9-CM or ICD-10-CM code describing the patient's stated reason for seeking care at the time of outpatient registration. This is a seven-digit alphanumeric field that displays up to three occurrences.
PROCEDURE CODES AND DATES (01 – 06)	74 a – e	Enter the full code, including all required digits where applicable, for the principal procedure (first code). Enter the date (in MMDDYY format) that the procedure was performed during the billing period (within the 'from' and 'through' dates of services in Form Locator 6).
ESRD HOURS		Enter the number of hours a patient dialyzed on peritoneal dialysis.
ADJUSTMENT REASON CODE		Not required for new claim entry. Adjustment reason codes are applicable only on adjustments TOB XX7 and XX8.
REJECT CODE		Not required by provider. For Medicare contractor use only.
NON PAY CODE		Not required by provider. For Medicare contractor use only.
ATT PHYS	76	This field identifies the LICENSED **attending physician's** identification number or Unique Physician Identification Number (UPIN) Code. This is a six-digit alphanumeric field.
NPI	76	This field identifies the NPI number.
L	76	This field identifies the last name of the attending physician.
F	76	This field identifies the first name of the attending physician.
M	76	This field identifies the middle initial of the attending physician.
SC		This field identifies the attending physician's specialty code. This information will automatically populate when the claim is submitted.
OPR PHYS	77	This field identifies the physician who performed the principal procedure. Inpatient Part A Hospital – Identifies the physician who performed the principal procedure. If no principal procedure is performed, leave blank. Outpatient Hospital – Identifies the physician who performed the principal procedure. If there is no principal procedure, the physician who performed the surgical procedure most closely related to the principal diagnosis is entered. Use the format for inpatient. Other bill types - Not required. Please note that if a surgical procedure is performed, and entry is necessary, even if the performing physician is the same as the admitting/attending physician.
NPI	77	This field identifies the N number.
L	77	This field identifies the last name of the operating physician.
F	77	This field identifies the first name of the operating physician.
M	77	This field identifies the middle initial of the operating physician.
SC		This field identifies the operating physician's specialty code. This information will automatically populate when the claim is submitted.

Field Name	UB-04 X-Ref.	Description
OTH OPR	78 & 79	This field identifies the 'Other Operating' licensed physician.
NPI	78 & 79	This field identifies the NPI number.
L	78 & 79	This field identifies the last name of the other operating physician.
F	78 & 79	This field identifies the first name of the other operating physician.
M	78 & 79	This field identifies the middle initial of the other operating physician.
SC		This field identifies the other operating physician's specialty code. This information will automatically populate when the claim is submitted.
REN PHYS	78 & 79	This field identifies the rendering physician.
NPI	78 & 79	This field identifies the NPI number.
L	78 & 79	This field identifies the last name of the rendering physician.
F	78 & 79	This field identifies the first name of the rendering physician.
M	78 & 79	This field identifies the middle initial of the rendering physician.
SC		This field identifies the rendering physician's specialty code. This information will automatically populate when the claim is submitted.
REF PHYS	78 & 79	This field identifies the Referring Physician. This field will be used by all providers as applicable.
NPI	78 & 79	This field identifies the National Provider Identifier number.
L	78 & 79	This field identifies the last name of the referring physician.
F	78 & 79	This field identifies the first name of the referring physician.
M	78 & 79	This field identifies the middle initial of the referring physician.
SC		This field identifies the referring physician's specialty code. This information will automatically populate when the claim is submitted.

UB-04 Claim Entry – Page 4

The Remarks Page (Figure 46) is used to transmit information submitted on automated claims, and it gives Palmetto GBA staff a mechanism to make comments on claims that need special consideration for adjudication. Providers may utilize Page 4 to:

- Justify claims filed untimely
- Justify adjustments to paid claims (required when using the 'D9' Condition Code)
- Justify cancels to paid claims
- Justify other reasons that may delay claim adjudication

INST Claim Entry Screen – Page 4 (MAP1714) – Field descriptions are provided in the table following Figure 46.

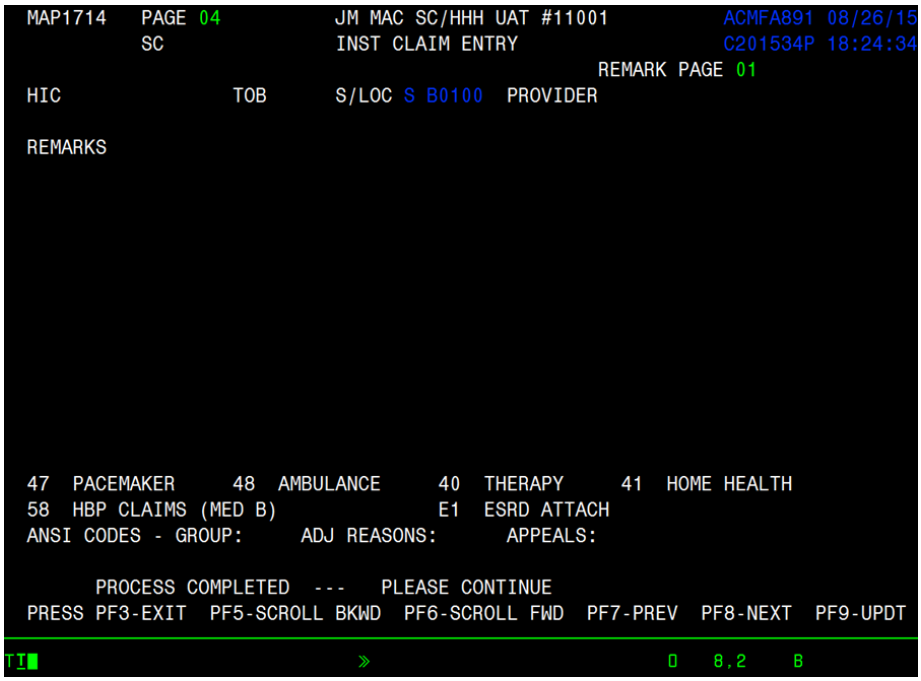


Figure 46 – UB-04 Claim Entry, Page 4

Field Name	UB-04 X-Ref.	Description
REMARK PAGE 01		There are a total 3 pages to enter remarks. Press [F6] to advance to the next page. The page number will change each time you press [F6].
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
REMARKS	80	Maximum of 711 positions/characters can be entered. Enter any remarks needed to provide information not reported elsewhere on the bill, but which may be necessary to ensure proper Medicare payment. This field carries the remarks information as submitted on automated claims, as well as provides internal staff with a mechanism to provide permanent comments regarding special considerations that played a part in adjudicating the claim, e.g., the Medical Review Department may use this area to document their rationale for the final medical determination or to provide additional information to the Waiver Employee to assist that individual with claim finalization. The remarks field is also used for Providers to furnish justification of late filed claims that override the Medicare contractor's existing reason code for timeliness. The following information must be entered on the first line. Additional information may be entered on the second and subsequent lines of the remarks section for further justification. Select one of the following reasons and enter the information exactly as it appears below: Justify: MSP involvement Justify: SSA involvement

Field Name	UB-04 X-Ref.	Description
		Justify: PRO Review involved Justify: Other involvement
[Attachments]		The following provides information on attachments: 47 = Pacemaker – No longer used. 48 = Ambulance – Not used. 40 = Therapy – Not used. 41 = Home Health – Not used. 58 = HBP Claims (Med B) – Not used. E1 = ESRD – Not used.
ANSI CODES GROUP		Identifies the general category of payment adjustment. Used for claims submitted in an ANSI automated format only.
ADJ REASONS		Claim adjustment standard reason code that identifies appeals codes for inpatient or outpatient.
APPEALS		Identifies ANSI appeals codes for inpatient or outpatient.

UB-04 Claim Entry – Page 5

Page five of the UB-04 Claim Entry screen (Figure 47) is used to enter a patient's payer information.

INST Claim Entry Screen – Page 5 (MAP1715) – Field descriptions are provided in the table following Figure 47.

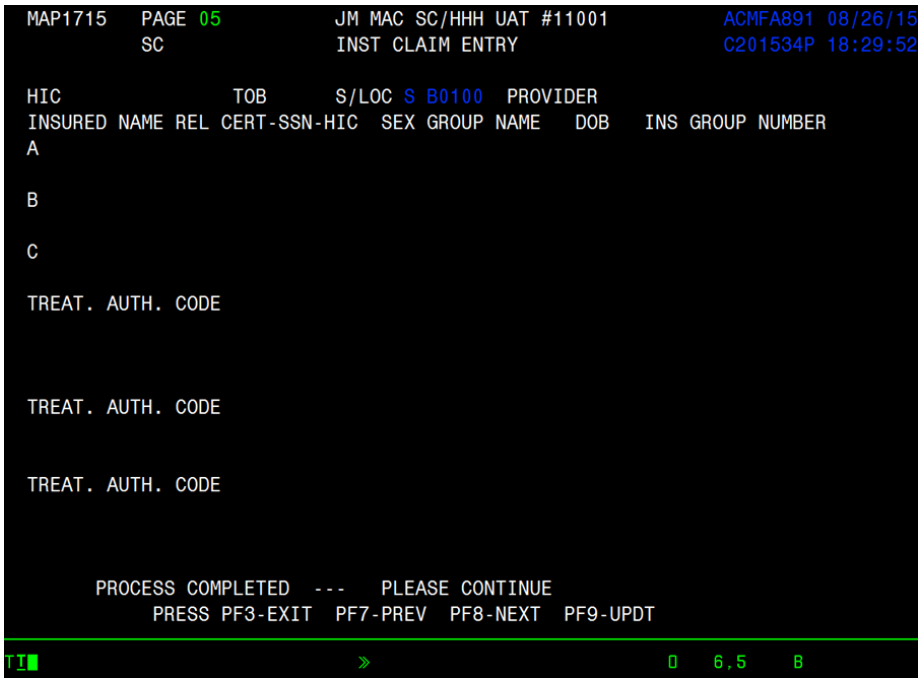


Figure 47 – UB-04 Claim Entry, Page 5

Field Name	UB-04 X-Ref.	Description
HIC	60	The beneficiary's Medicare Health Insurance Claim number.
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
INSURED	58 A,	Maximum of 25 digits; Last Name, First Name. On the same line that

Field Name	UB-04 X-Ref.	Description
NAME (A – C)	B, C	corresponds to the line on which Medicare payer information is reported, enter patient's name as reported on his/her Medicare health insurance card. If billing supplemental insurance, enter the name of the individual insured under Medicare on line A and enter the name of the individual insured under a supplemental policy on line B. **Note**: MSP claims cannot be submitted or corrected in DDE.
REL (A – C)	59 A, B, C	On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is reported, enter the code indicating the relationship of the patient to the identified insured. The following codes are for Medicare requirements only. Other payers may require codes not reflected. Refer to your UB-04 Manual for valid values.
CERT.-SSN-HIC-ID (A – C)	60 A, B, C	Enter the patient's Health Insurance Card Number (HICN) if Medicare is the primary payer.
SEX (A – C)		The sex of the beneficiary/patient. Refer to your UB-04 Manual for valid values.
GROUP NAME (A – C)	61 A, B, C	Enter the name of the group or plan through which that insurance is provided. Entry required, if applicable.
DOB		The insured's date of birth (in MMDDCCYY format).
INS GROUP NUMBER (A – C)	62 A, B, C	Not displayed on new claims. MSP claims cannot be submitted in DDE. If viewing this page through the claims inquiry menu and an MSP claim was submitted, this field identifies the Insurance Group identification number, control number, or code assigned by that health insurance company to identify the group under which the insured individual is covered.
TREAT. AUTH CODE	63 A, B, C	The HHPPS Treatment Authorization Code for home health claims identifies a matching key to the OASIS (Outcome Assessment Information Set) of the patient. This field is comprised of a 18-digit alpha-numeric code that is produced by the Grouper software based on input to the OASIS as follows: Positions 1 – 2 = M0030 – Start of care date (2-digit number for the year) Positions 3 – 4 = M0030 – Start of care date (alpha characters derived from MM/DD code; ex: 09/01 = JK) Positions 5 – 6 = M0090 – Date assessment completed (2-digit number for the year) Positions 7 – 8 = M0090 – Date assessment completed (alpha characters derived from the MM/DD; ex: 01/01 = AA) Position 9 = M0100 – Reason for assessment currently being completed (numeric) Position 10 = M0110 – Episode timing (numeric based on the actual episode; ex: episode 1 = '1') Position 11 = Clinical severity points under equation 1 (alpha code) Position 12 = Functional severity points under equation 1 (alpha code) Position 13 = Clinical severity points under equation 2 (alpha code) Position 14 = Functional severity points under equation 2 (alpha code) Position 15 = Clinical severity points under equation 3 (alpha code) Position 16 = Functional severity points under equation 3 (alpha code) Position 17 = Clinical severity points under equation 4 (alpha code) Position 18 = Functional severity points under equation 4 (alpha code) This field is also used to identify a Centers for Excellence or Provider Partnership Demonstration for NOA Type of Bill '11A' and '11D'. The valid values are:

Field Name	UB-04 X-Ref.	Description
		'09' = Discharge from agency '10' = Discharge from agency – no visits completed after start/resumption of care assessment '07' = Centers for Excellence '08' = Providers Partnership Demonstration Note: This field is also used to report the Unique Tracking Number (UTN) associated with the Medicare Payer iteration. For bill types other than 32X or 33X, report the UTN in positions 1-14. For 32X bill types, report the 14-position UTN immediately following the 18-position OASIS Treatment Authorization Number. The valid format of the UTN is: Positions 1-2 = MAC Jurisdiction (alpha-numeric) Position 3 = A (Part A program, or H for Home Health/Hospice Program) Positions 4-14 = Numeric

UB-04 Claim Entry – Page 6

The following information can be found on Page 6 of the UB-04 Claim Entry screen (Figure 48):

- Medicare Secondary Payer (MSP) address
- Payment data (coinsurance, deductible, etc.)
- Pricer data (DRG, etc.).

Note: MSP claims cannot be submitted or corrected in DDE. Providers may view data on this screen through the claims inquiry screen, but will not enter information on this page.

INST Claim Entry Screen – Page 6 (MAP1716) – Field descriptions are provided in the tables following Figure 48.

```
MAP1716   PAGE 06          JM MAC SC/HHH UAT #11001          ACMFA891 08/26/15
          SC               INST CLAIM ENTRY                  C201534P 18:34:20

HIC              TOB      S/LOC S B0100  PROVIDER
           MSP ADDITIONAL INSURER INFORMATION
1ST INSURERS ADDRESS 1
1ST INSURERS ADDRESS 2
               CITY                  ST     ZIP
2ND INSURERS ADDRESS 1
2ND INSURERS ADDRESS 2
               CITY                  ST     ZIP
PAYMENT DATA ---  DEDUCTIBLE             COIN           CROSSOVER IND
PARTNER ID

PAID DATE         PROVIDER PAYMENT               PAID BY PATIENT
REIMB RATE         RECEIPT DATE 082615  PROVIDER INTEREST
CHECK/EFT NO             CHECK/EFT ISSUE DATE           PAYMENT CODE
                           PRICER DATA
DRG      OUTLIER AMT              TTL BLNDED PAYMT            FED SPEC
GRAMM RUDMAN ORIG REIMBURSEMENT AMT            NET INL
TECH PROV DAYS      TECH PROV CHARGES
 OTHER INS ID             CLINIC CODE
      PROCESS COMPLETED  ---   PLEASE CONTINUE
PRESS PF3-EXIT  PF7-PREV PAGE  PF9-UPDT  ENTER-CONTINUE
TI                              »                          0   6,26   B
```

Figure 48 – UB-04 Claim Entry, Page 6

Field Name	UB-04 X-Ref.	Description
HIC	60	The beneficiary's Medicare Health Insurance Claim number.

Field Name	UB-04 X-Ref.	Description
TOB	4	The Type of Bill identifies type of facility, type of care, source and frequency of this claim in a particular period of care. Refer to your UB-04 Manual for valid values.
S/LOC		The Status code identifies the condition and of the claim within the system The Location code identifies where the claim resides within the system.
PROVIDER	57	This field displays the provider identification number.
INSURER'S ADDRESS 1 AND 2	58 A, B, C	Enter the address of the insurance company that corresponds to the line on which Medicare payer information is reported FL58 A, B, C.
CITY 1 AND 2	58 A, B, C	Enter the specific city of the insurance company.
ST 1 AND 2	58 A, B, C	Enter the specific state of the insurance company.
ZIP 1 AND 2	58 A, B, C	Enter the specific zip code of the insurance company.

Payment Data – This information is available for viewing in Detail Claim Inquiry (Option 12) immediately after the claim is updated/entered in DDE.

Field Name	Description
Payment Data	
DEDUCTIBLE	Amount applied to the beneficiary's deductible payment.
COIN	Amount applied to the beneficiary's co-insurance payment.
CROSSOVER IND	**The Crossover Indicator** identifies the Medicare payer on the claim for payment evaluation of claims crossed over to their insurers to coordinate benefits. Valid values are: 1 = Primary 2 = Secondary 3 = Tertiary
PARTNER ID	Identifies the Trading Partner number.
PAID DATE	This is the actual date that claim was processed for payment consideration.
PROVIDER PAYMENT	This is the actual amount that provider was reimbursed for services.
PAID BY PATIENT	This is the actual amount reimbursed to beneficiary. Not utilized in DDE.
REIMB RATE	Provider's specific reimbursement rate (PPS).
RECEIPT DATE	Date claim was first received in the FISS system.
PROVIDER INTEREST	Interest paid to the provider.
CHECK/EFT NO	Displays the identification number of the check or electronic funds transfers.
CHECK/EFT ISSUE DATE	Displays the date the check was issued or the date the electronic funds transfer occurred.
PAYMENT CODE	Displays the payment method of the check or electronic funds transfer. Valid values are: ACH = Automated Clearing House or Electronic Funds Transfer CHK = Check NON = Non-payment data
Pricer Data	
DRG	The Diagnostic Related Grouping Code assigned by the pricer's calculation.
OUTLIER AMT	The Outlier Amount qualified for outlier reimbursement.
TTL BLNDED PAYMENT	Not utilized in DDE.
FED SPEC	Not utilized in DDE.

Field Name	Description
GRAMM RUDMAN ORIG REIM. AMT	The Gramm Rudman Original Reimbursement Amount.
NET INL	Not utilized in DDE.
TECH PROV DAYS	**Technical Provider Days:** The number of days for which the provider is liable.
TECH PROV CHARGES	**Technical Provider Charges**: The dollar amount for which the provider is liable.
OTHER INS ID	Not utilized in DDE.
CLINIC CODE	Not utilized in DDE.

Roster Bill Entry

To access the Roster Bill Entry page, open the Claim and Attachments Entry Menu (select option 02 from the Main Menu) and then select option 87. The DDE Roster Bill page (Figure 49) will display. This page allows providers to enter their pneumococcal pneumonia and flu shots in a roster bill format. After typing roster bill information, press **[F9]** to transmit the claim.

When completing the roster bill, providers should observe the following points

- Only one date of service per roster page
- A maximum of ten patients per roster page may be reported on a DDE roster page

Vaccine Roster For Mass Immunizers Screen (MAP1681) - Field descriptions are provided in the table following Figure 49.

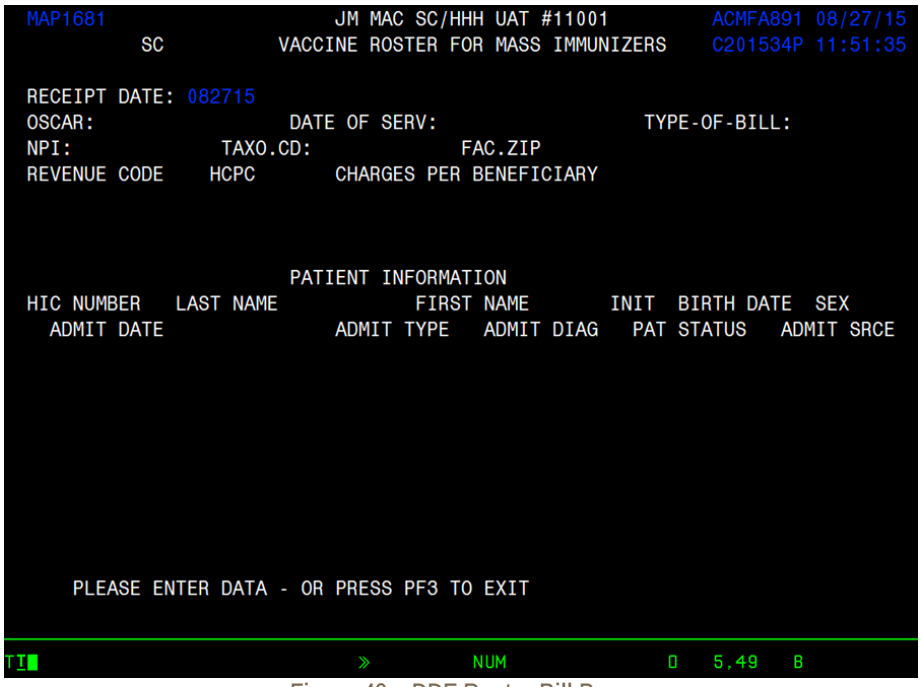


Figure 49 – DDE Roster Bill Page

Field Name	Description
RECEIPT DATE	The system date that the claim was received by the Medicare contractor.

Field Name	Description
OSCAR	The identification number of the institution that rendered services to the beneficiary/patient. **Note:** The system will auto-fill the Medicare provider number used when logging on to the DDE system. If your facility has sub-units (SNF, ESRD, Home Health, Inpatient, etc.) the Medicare OSCAR number must be changed to reflect the OSCAR number for which you wish to submit claims. If the Medicare OSCAR number is not changed for your sub-units, the claims will be processed under the incorrect OSCAR number.
DATE OF SERVICE	The date the service was rendered to the beneficiary (in MMDDYYYY format).
TYPE-OF-BILL	Enter the first two digits of the type of bill being submitted as a roster bill. Valid values are: 22 = Skilled Nursing Facility (SNF) Inpatient Part B 23 = SNF Outpatient 34 = Home Health (Part B Only) 72 = Independent or Hospital-Based Renal Dialysis Facility 75 = Comprehensive Outpatient Rehabilitation Facility 85 = Critical Access Hospital The system will autofill the third digit of the bill type when the roster is transmitted.
NPI	This field identifies the National Provider Identifier number.
TAXO.CD	This field identifies a collection of unique alpha numeric codes. The code set is structured into here distinct levels including Provider Type, Classification, and Area of Specialization.
FAC.ZIP	This field identifies the provider or subpart ***nine***-digit ZIP code.
REVENUE CODE	Enter the specific accommodation or service that was billed on the claim. This should be done by line item. Valid values are 0636 ***or*** 0770.
HCPC	HCPCS applicable to ancillary services being billed.
CHARGES PER BENEFICIARY	Enter the charges per revenue code being charged to the beneficiary.
After all the above information is entered, press the 'Enter' key. The cursor will automatically move to the top of the page. Use the 'Tab' key to move to the 'HIC' field and enter the information listed below.	
Patient Information	
HIC NUMBER	The health insurance claim number assigned when a beneficiary becomes eligible for Medicare.
LAST NAME	Enter the last name of the patient as it appears on the patient's Medicare Card or other Medicare notice.
FIRST NAME	Enter the first name of the patient as it appears on the patient's Medicare Card or other Medicare notice.
INIT	Enter the middle initial of the patient (if applicable).
BIRTH DATE	Enter the patient's date of birth (in MMDDYYYY format).
SEX	Enter the sex of the patient. Valid values are: M or F
ADMIT DATE	This field identifies the date of the patient's admission (the system will auto fill this date when the roster is transmitted).
ADMIT TYPE	This field identifies the code indicating the priority of admission. The valid values are: '1' = Emergency '2' = Urgent '3' = Elective '4' = Newborn '5' = Trauma Center
ADMIT DIAG	This field identifies the diagnosis code describing the inpatient condition at the time of the admission (when the roster is transmitted, the system will auto fill the diagnosis code based on the type of vaccine that is being billed).

Field Name	Description
PAT STATUS	This field identifies the code indicating the patient's status at the ending service date in the period (the system will auto fill the patient status when the roster is transmitted).
ADMIT SRCE	This field identifies the way a patient was referred (the system will auto fill this field when the roster is transmitted).

ESRD CMS-382 Form

The ESRD attachment form allows ESRD providers to inquire, update, and enter an ESRD method selection data. Select option '**57**' from the Claim and Attachments Entry Menu. Enter a HIC number and function. Choose one of the following functions:

- E = Entry
- U = Update
- I = Inquiry

Press **[ENTER]** to access the additional fields for entry. If a beneficiary is currently on file when you enter an '**E**' for the method selection form, the system will automatically enter the beneficiary's last name, first name, middle initial, date of birth, and sex based on the information stored on the beneficiary file. In addition, the system should allow access to the provider number, dialysis type, and selection or change fields.

ESRD CMS-382 Inquiry screen (MAP1391) – Field descriptions are provided in the table following Figure 50.

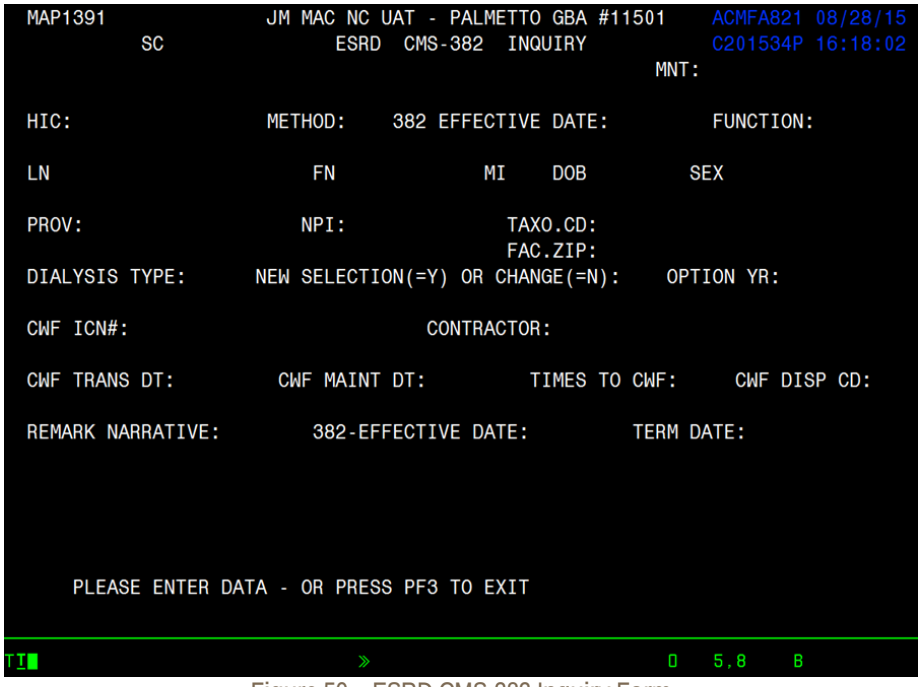


Figure 50 – ESRD CMS-382 Inquiry Form

Field Name	Description
HIC	The beneficiary's Health Insurance Card number.

Field Name	Description
METHOD	The method of home dialysis selected by the beneficiary. Valid values are: 1 = Method I – Beneficiary receives all supplies and equipment for home dialysis from an ESRD facility and the facility submits the claims for their services. 2 = Method II – Beneficiary deals directly with one supplier and is responsible for submitting their own claim
382 EFFECTIVE DATE	Identifies the date the Beneficiary's ESRD Method Selection becomes effective on the (HCFA-382) form.
FUNCTION	Three valid functions include: E = Entry U = Update I = Inquiry
LN	Last name of the beneficiary at the time the method selection occurred.
FN	First name of the beneficiary.
MI	Middle Initial of the beneficiary, if applicable.
DOB	Beneficiary's date of birth.
SEX	Sex of the beneficiary.
PROV	Enter the ESRD Provider number or the facility for which you are entering the ESRD attachment. The Medicare Provider number will system fill with the Provider number you used to log onto the DDE system. Therefore, if you have sub-units (multiple ESRD facilities) you will need to change the Provider number to reflect the ESRD facility for which the attachment information is being entered.
NPI	This field identifies the provider National Provider Identifier number.
TAXO.CD	Taxonomy Code: This field identifies a collection of unique alphanumeric codes. The code set is structured in three distinct levels including provider type, classification, and area of specialization.
FAC.ZIP	This field identifies the provider or subpart nine-digit ZIP code.
DIALYSIS TYPE	Valid types of dialysis include: 1 = Hemodialysis 2 = Continuous ambulatory peritoneal dialysis (CAPD) 3 = Continuous cycling peritoneal dialysis (CCPD) 4 = Peritoneal Dialysis
NEW SELECTION OR CHANGE	Indicates an exception to other ESRD data. Valid values are: Y = Selection – Entered on initial selection or for exceptions such as when the option year is equal to the year of the select date N = Change – Entered for a change in selection, e.g., option year is one year greater than the year of select date
OPTION YR	Identifies the year that a beneficiary selection or change is effective. A selection change becomes effective on January 1 of the year following the year the ESRD beneficiary signed the selection form.
CWF ICN#	Common Working File (CWF) Internal Control Number (ICN). FISS inserts this number on the ESRD Remarks screen to ensure the correction is being made to the appropriate ESRD Remark segment.
CONTRACTOR	Identifies the carrier or Medicare contractor responsible for a particular ESRD Maintenance file.
CWF TRANS DT	The date that information was transmitted to the CWF.
CWF MAINT DT	Identifies the date that a CWF response was applied to a particular ESRD record.
TIMES TO CWF	Number of times the record was transmitted to the CWF.
CWF DISP CD	The CWF Disposition Code. Valid values include: 01 = Debit accepted, no automated adjustment 02 = Debit accepted, automated adjustment 03 = Cancel accepted 04 = Outpatient history only accepted 50 = Not in file (NIF) 51 = True NIF on HCFA Batch System

Field Name	Description
	52 = Mater record housed at another CWF site 53 = Record in HCFA alpha match 55 = Name/personal character mismatch 57 = Beneficiary record archived, only skeleton exists 58 = Beneficiary record blocked for cross reference 59 = Beneficiary record frozen for clerical correction 60 = Input/output error on data 61 = Cross-reference database problem AB = Transaction caused CICS abnormal end of job (abend) BT = History claim not present to support spell CI = CICS processing error CR = Crossover reject ER = Consistency edit reject UR = Utilization reject RD = Transaction Error
REMARK NARRATIVE	Valid Remark Narrative types include: M1 = Method I M2 = Method II
382 EFFECTIVE DATE	The method effective date. Valid values are: Y = The 382 effective date is equal to the 382 signature date N = The 382 effective date will be January 1 of the following year
TERM DATE	Projected date of termination of dialysis coverage.

SECTION 6 – CLAIM CORRECTION

The Claim and Attachments Correction Menu displays (Figure 51) when '**03**' is chosen from the Main Menu. The detailed explanations for the claim page screens are provided in Section five (5) of this manual.

Claim and Attachments Correction Menu Screen (MAP1704)

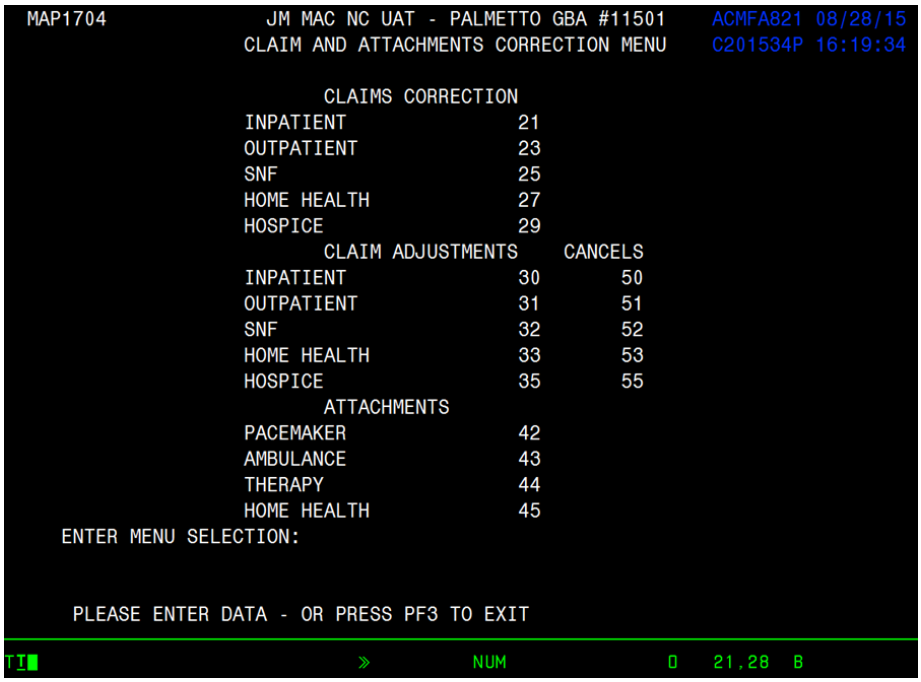


Figure 51 – Claim and Attachments Correction Menu

Claim correction allows you to:

- Correct Return To Provider (RTP) claims
- Suppress RTP claims that you do not wish to correct
- Adjust claims
- Cancel claims

Note: The system will automatically enter your provider number into the PROVIDER field. If the facility has multiple provider numbers, the user will need to change the provider number to inquire or input information. **[TAB]** to the PROVIDER field and type in the correct provider number.

Online Claims Correction

If a claim receives an edit (FISS reason code), a Return to Provider (RTP) is issued. An RTP is generated after the transmission of the claim. The claim is returned for correction. Until the claim is corrected via DDE or hardcopy, it will not process. When an RTP is received, the claim is given a Status/Location code beginning with the letter 'T' and routed to the Claims Summary Inquiry screen. Claims requiring correction are located on the Claim Summary screen the day after claim entry. It is not possible to correct a claim until it appears on the summary screen. Providers are permitted to correct **only** those claims appearing on the summary screen with status 'T'. Claims that have been given 'T' status have not yet been processed for payment consideration, so it is important to review your claims daily and correct them in order to avoid delays in payment.

Claim Summary Inquiry

Once an option is chosen from the Claim and Attachments Correction Menu, the Claim Summary Inquiry screen (Figure 52) will display.

Claim Summary Inquiry Screen (MAP1741) – Field descriptions are provided in the table following Figure 52.

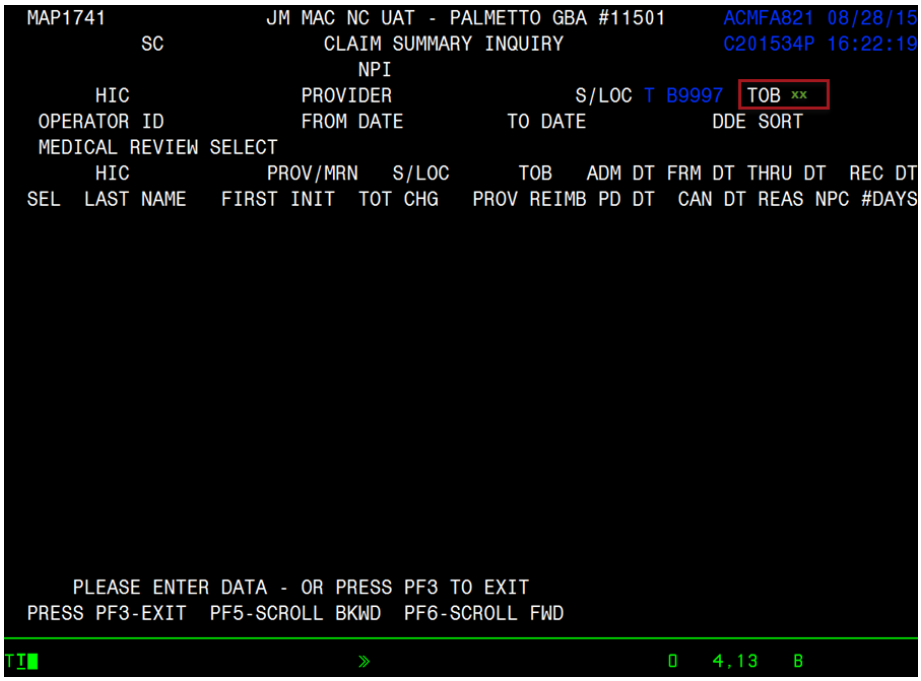


Figure 52 – Claim Summary Inquiry

Certain information is already completed, including the provider number, the status/location where RTP claims are stored (T B9997), and the first two digits of the type of bill. To narrow the selection, enter any or all of the information in the following table.

Field Name	Description
DDE SORT	Allows multiple sorting of displayed information. Valid values include: ' ' = TOB/DCN (Current default sorting process, S/LOC, Name) M = Medical Record number sort (Ascending order, HIC) N = Name sort (Alpha by last name, first initial, Receipt Date, MR#, HIC) H = HICN sort (Ascending order, Receipt Date, MR#) R = Reason Code sort (Ascending Order, Receipt Date, MR#, HIC) D = Receipt Date sort (Oldest Date displaying first, MR#, HIC)
MEDICAL REVIEW SELECT	Used to narrow the claim selection for inquiry. This will provide the ability to view pending or returned claims by medical review category. Valid values include: ' ' = Selects all claims 1 = Selects all claims 2 = Selects all claims excluding Medical Review 3 = Selects Medical Review only

To see a list of the claims that require correction, press **[ENTER]**. The selection screen will then display all claims that have been returned for correction (status/location T). To narrow the scope of the claims viewed, enter one of the following selection criteria, type of bill, from date, to date, and HIC number. If the claim you are looking for does not display on the screen, do the following:

- Verify the HIC number that you typed.
- Verify the 'from' and 'through' dates.
- Verify that the type of bill (TOB) is the same as the TOB on the claim you originally submitted. If not, **[TAB]** to the TOB field and enter the first two digits of the TOB for the claim you are trying to retrieve.
- If you still cannot find the claim, back out of Claims Correction (press **[F3]**) all the way to the Main Menu. Choose Inquiry (option 01), then Claims (option 12), and select the claim. Check the

status/location (S/LOC). **Only claims in status location T B9997 can be corrected.** Status locations that cannot be corrected include:

P B9997 – This claim has paid. An adjustment is required in order to change a paid claim.
P 09998 – This claim was paid but due to its age, it has been moved to off-line history. Timeliness of filing will not allow you adjust this claim.
P B9996 – This claim is waiting to be released from the 14-day payment floor (not showing on the RA). No correction allowed.
R B9997 – This claim was rejected. Submit a new claim or an adjustment.
D B9997 – This claim was denied and may not be corrected or adjusted.

Claims Correction Processing Tips

- The Revenue Code screen has multiple sub-screens. If you have more Revenue Codes than can fit on one screen, press **[F6]** to go the next sub-screen. Press **[F5]** to go back to the previous screen.
- You can also get from page to page by entering the page number in the top left corner of the screen (Page).
- Reason codes will display at the bottom left of the screen to explain why the claim was returned. Up to 10 reason codes can appear on a claim.
- Pressing **[F1]** will access the reason code file and automatically display the narrative for the first reason code listed on the left corner of the claim screen. Subsequent reason codes can be entered manually to view the narrative.
- Press **[F3]** to return to the claim.
- The reason code file can be accessed from any claim screen by pressing **[F1]**.
- The inquiry screen can also be accessed by typing the option number in the 'SC' field in the upper left hand corner of the screen. For example, enter '10' for Beneficiary information screen in the 'SC' field and press **[Enter]**. Press **[F3]** to return to the claim.

Correcting Revenue Code Lines

To delete an entire Revenue Code line:

- **[TAB]** to the line and type zeros over the top of the Revenue Code to be deleted or type '**D**' in the first position.
- Press **[HOME]** to go to the Page Number field. Press **[ENTER]**. The line will be deleted.
- Next, add up the individual line items and correct the total charge amount on Revenue Code line (0001).

To add a Revenue Code line:

- Tab to the line below the total line (0001 Revenue Code).
- Type the new Revenue Code information.
- Press **[HOME]** to go to the Page Number field. Press **[ENTER]**. The system will resort the Revenue Codes into numerical order.
- Perform the 'delete' function on Revenue Code line (0001) and add it back to the bottom to correct the total charges and units.

Changing total and non-covered charge amounts:

- **[TAB]** to get to the beginning of the total charge field on a line item.
- Press **[END]** to delete the old dollar amount. It is very important ***not*** to use the spacebar to delete field information. Always use **[END]** when clearing a field.
- Type the new dollar amount without a decimal point. Example: for $23.50 type '2350'.
- Press **[ENTER]**. The system will align the numbers and insert the decimal point.
- Correct the totals line, if necessary.
- To exit without transmitting any corrections, press **[F3]** to return to the selection screen. Any changes made to the screen will not be updated.
- Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom left of the screen. Continue the correction process until the system takes you back to the claim correction summary.

- The on-line system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check (S B2500, unless otherwise set in the System Control file). The claim will continue forward when nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the corrected claim has been successfully updated, the claim will disappear from the screen. The following message will appear at the bottom of the screen: PROCESS COMPLETED – ENTER NEXT DATA.

RTP Selection Process

From the Claim Summary Screen (Figure 52), select the claim to be corrected by tabbing to the 'SEL' field for the first line of the claim to be corrected. Type a '**U**' or '**S**' and press **[ENTER]**. The patient's original UB-04 claim will display. (This will be MAP1711, the first page of the claim).

Type Information:

- Use the Function keys listed at the bottom of the screen to move through the claim (i.e., **[F8]** to go to the next screen, **[F7]** to back up a screen).
- The Revenue Code screen has multiple sub-screens. If you have more revenue codes than can fit on one screen, press **[F6]** to go the next sub-screen. Press **[F5]** to go back to the first screen.
- You can also get from page to page by entering the page number in the top left of the screen.

Reason Codes will appear at the bottom of the screen (Figure 53) to explain why the claim was returned. Up to ten reason codes can appear on a claim.

INST Claim Update Screen – Claim Page 1 (MAP1711)

```
 MAP1711   PAGE 01          JM MAC SC/HHH UAT #11001          ACMFA891 08/28/15
           SC               INST CLAIM UPDATE                 C201534P 16:31:37
 HIC              TOB 131  S/LOC S B0100 OSCAR                  SV:    UB-FORM
NPI           TRANS HOSP PROV                  PROCESS NEW HIC
PAT.CNTL#:                     TAX#/SUB:                TAXO.CD:
 STMT DATES FROM 040115  TO 040115  DAYS COV      N-C       CO      LTR
 LAST                           FIRST                MI    DOB
 ADDR 1                                 2
 3                                  4                                CARR:
 5                                  6                                 LOC:
ZIP           SEX   MS   ADMIT DATE        HR    TYPE 3 SRC 2 D HM      STAT 30
   COND CODES 01    02    03    04    05    06    07    08    09    10
 OCC CDS/DATE 01 11 040115 02          03          04          05
              06          07          08          09          10
   SPAN CODES/DATES 01                 02                03
04                 05                 06                07
08                 09                 10                FAC.ZIP
  DCN
      V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 A2       84.42 PR 2   02 78 292290021          03
04                       05                       06
07                       08                       09
15331                                                  <== REASON CODES
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT

TI                          »                        0   3.7    B
```

Figure 53 – UB-04 Claim Entry, Page 1

Press **[F1]** to access the Reason Code file (Figure 53). The system automatically pulls up the first reason code with its message. The message will identify the fields that are in error and will suggest corrective action. Press **[F3]** to return to the claim, or type in an additional reason code and press **[ENTER]**.

Reason Codes Inquiry Screen (MAP1881). Field descriptions are in the table following Figure 29 of this manual.

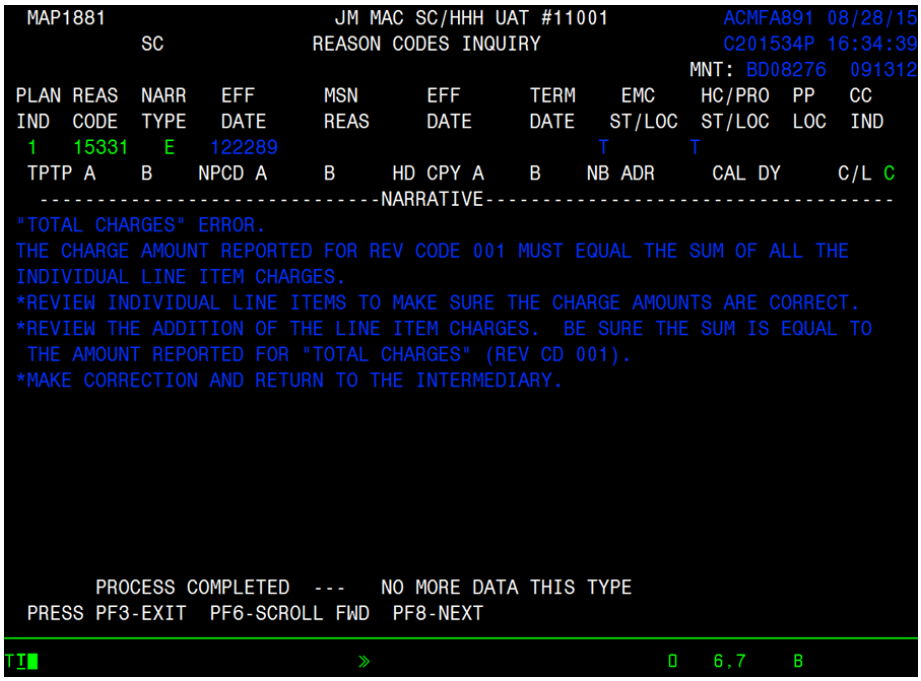


Figure 54 – Reason Codes Inquiry Screen

Type Information:

- The reason codes may be accessed from any claim screen.
- The Inquiry screen can be accessed by typing the option number in the 'SC' field in the upper left hand corner of the screen. For example, type '15' in the 'SC' field to access the DX/PROC Codes screen. Press **[F3]** to return to the claim.

Press **[F3]** to return to the selection screen. Any changes made to the screens will not be updated. Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. If the claim still has errors, reason codes will appear at the bottom of the screen. Continue the correction process until the system takes you back to the Claim Correction Summary.

Note: The online system does not fully process a claim. It processes through the main edits for consistency and utilization. The claim goes as far as the driver for duplicate check. The claim will continue forward when the nightly production (batch) is run. Potentially, the claim could RTP again in batch processing.

When the **corrected** claim has been successfully updated, the claim will disappear from the screen. The following message will display at the bottom of the screen PROCESS COMPLETED - ENTER NEXT DATA.

Suppressing RTP Claims

A feature exists within DDE that allows a claim to be suppressed because RTP claims do not purge from the FISS for 60 days or longer. This is a helpful function for RTP claims filling up unnecessary space under the Claim Correction Menu option. This action will hide from view the claims in the Claim Correction Menu option; however, all claims will continue to display through the Inquiry Menu option until they purge from the system.

Type a '**Y**' in the SV field located in the upper right hand corner of page 1 and then press **[F9]**. The system will return you to the Claim Summary Inquiry screen.

NOTE: This action CANNOT be reversed, which means the claim cannot be reactivated. Be sure that you want to perform this function before doing so.

CLAIMS SORT OPTION

DDE claims are normally displayed in type of bill order depending on the two-digit number selected from the Claim and Attachments Correction Menu. The claim sort option allows a provider to choose the sort order. To sort the DDE claims, type one of the following values in the DDE SORT field and press **[ENTER]**:

M = Displays claims in Medical Record Number order. The dual-purpose field labeled PROV/MRN will display the provider number unless you choose this sort option.
N = Displays claims in the beneficiary last name order.
H = Displays claims in Health Insurance Claim (HIC) number order.
R = Displays claims in Reason Code order.
D = Displays claims in Receipt Date order.

Claims and Attachments Corrections

ADJUSTMENTS

When claims are keyed and submitted through DDE or the electronic claims filing system for payment consideration, the user can sometimes make entry mistakes that are not errors to the DDE/FISS system. As a result, the claim is processed through the system to a final disposition and payment. To change this situation, the on-line claim adjustment option can be used to submit adjustments for previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter 'P' and is recorded on the claim status inquiry screen.

A claim cannot be adjusted unless it has been finalized and is reflected on the remittance advice. In addition, a home health Request for Anticipated Payment (RAP), TOB 322, cannot be adjusted.

Providers must be very careful when creating adjustments. If you go into the adjustment system and update a claim without making the right corrections, the adjustment will still be created and process through the system. Errors could cause payment to be taken back unnecessarily.

No adjustments can be made on the following claims:

- **R** = Rejected claims unless the claim posted to CWF.
- View the TPE-TO-TPE (see Figure 44) field to determine if the claim posted to CWF. If there is an 'X' in the TPE-TO-TPE field, the claim did not post to CWF and cannot be adjusted. If the TPE-TO-TPE field is blank or has a value other than 'X' and adjustment can be performed.
- **T** = RTP claims
- **D** = Denied claims (view the reason code narrative to determine if the claim was medically denied or denied for a non-medical reason)
- Type of Bill XXP (PRO adjustment) or XXI (Medicare contractor adjustment)

If a claim has been denied with a full denial, the provider cannot submit an adjustment through DDE. Any attempted adjustments will reject with Reason Code 30940 (a provider is not permitted to adjust a fully medically denied claim). If a claim has been fully denied for medical necessity reasons, no adjustments can be submitted. If the claim was partially denied for medical necessity, a provider may adjust the claim, but may only change/delete/add line items that were not denied.

To access the claim and make the adjustment:

1. Select the option on the Claim and Attachments Correction Menu for the type of claim to be adjusted and press **[ENTER]**. End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB.
2. Enter the HIC number and the FROM and TO dates of service, and then press **[ENTER]**. The system will automatically default the TOB frequency to an XX7. The HIC number field is now protected and may no longer be changed.

3. Indicate why you are adjusting the claim by entering the claim change condition code on Page 01 of the claim and a valid Adjustment Reason Code on Page 03. Valid Adjustment Reason Codes can be found typing '**16**' in the '**SC**' field in the upper left hand corner of the screen and pressing **[ENTER]**. Press **[ENTER]** again to view the entire list of valid codes and descriptions. If you wish to view the description of a code you want to use, enter the code in the 'Reason Code' field.
4. Give a short explanation of the reason for the adjustment in the remarks section on Page 04 of the claim.
5. To back out without transmitting the adjustment, press **[F3]**. Any changes made to the screens will not be updated.
6. Press **[F9]** to update/enter the claim into DDE for reprocessing and payment consideration. Claims being adjusted will still show on the claim summary screen. Always check the inquiry claim summary screen (option 12) to affirm location of the claim being adjusted.
7. Check the remittance advice to ensure that the claim adjusted properly.

CLAIM VOIDS/CANCELS

Using the Claim Cancels option, providers can cancel previously paid/finalized claims. After a claim is finalized, it is given a status/location code beginning with the letter 'P' and is recorded on the claim status inquiry screen. **A claim cannot be voided (canceled) unless it has been finalized and is reflected on the remittance advice.**

Providers must be very careful when creating cancel claims. If you go into the cancel option, be certain that you want to cancel the claim. If you do not want to cancel the claim after you have accessed it, hit [F3] to go back to the claims correction menu. Once you hit [F9], the cancel will be created and process through the system. This will cause payment to be taken back unnecessarily. Once a claim has been voided (canceled), no other processing can occur on that bill.

Important notes on cancels:

- All bill types can be voided except one that has been denied with full or partial medical denial.
- Do not cancel TOB XXP (PRO adjustments) or XXI (Medicare contractor Adjustments).
- A cancel bill must be made to the original paid claim.
- Providers may not reverse a cancel. Canceling a claim in error will cause payment to be taken back by the Medicare contractor.
- Providers cannot cancel an MSP claim. Provider must submit an adjustment even if the claims are being changed into a "no-pay" claim.
- Providers may/should add remarks on Claim Page 04 to document the reason for the cancel.
- After the cancel has been stored, the claim will appear in Status/Location S B9000.
- Cancels do not appear on provider weekly monitoring reports; therefore, use the Claim Summary Inquiry to follow the status/location of a cancel.

To access the claim and cancel it:

1. Select the option on the Claim and Attachments Correction Menu for the type of claim to be canceled and press **[ENTER]**. End Stage Renal Disease (ESRD), Comprehensive Outpatient Rehab Facilities (CORF), and Outpatient Rehab Facilities (ORF) will need to select the outpatient option and then change the TOB.
2. Enter the HIC number and the FROM and TO dates of service, and then press **[ENTER]**.
3. Select the claim to be canceled by typing an '**S**' in the '**SEL**' field beside the first line of the claim and then press **[ENTER]**. The HIC number field is now protected and may no longer be changed.
4. Indicate why you are voiding/canceling the claim by entering the claim change condition on Page 01 of the claim.
5. Give a short explanation of the reason for the void/cancel in the remarks section on Page 04 of the claim.
6. To back out without transmitting the void/cancel, press **[F3]**. Any changes made to the screens will not be updated.
7. Press **[F9]** to update/enter the cancel claim into DDE for reprocessing and payment retraction.

8. Check the remittance advice to ensure the claim canceled properly.

Valid Claim Change Condition Codes

Adjustment condition code will be needed to indicate the primary reason for initiating an on-line claim adjustment or void/cancel. Valid code values include:

D0 = Changes to service dates
D1 = Changes to charges – **Note**: When there are multiple changes to a claim in addition to changes to charges, the D1 "changes to charges" code value will take precedence.
D2 = Changes to Revenue Codes/HCPCS
D3 = Second or subsequent interim PPS bill
D4 = Change in GROUPER input
D5 = Cancel only to correct a HICN or Provider identification number – **For XX8 TOB only**
D6 = Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill) – **For XX8 TOB only**
D7 = Change to make Medicare the secondary payer
D8 = Change to make Medicare the primary payer
D9 = Any other change (Use this code only if no other code applies. Adjusted claims submitted with this condition code are manually reviewed.)
E0 = Change in patient status

SECTION 7 – ONLINE REPORTS

The Online Reports View function allows viewing of certain provider specific reports by the Direct Data Entry Provider. The purpose of the reports is to inform the providers of the status of claims submitted for processing and provide a monitoring mechanism for claims management and customer service to use in determining problem areas for providers during their claim submission process.

As reports are viewed on-line, it will be necessary to scroll (or toggle) between the left view (Scroll L) and the right view (Scroll Right). Use the **[F11]** key to move to the right and the **[F10]** key to return to the left.

To access the online reports, choose menu selection 04 from the DDE Main Menu. The Online Reports Menu will display (Figure 55).

Online Reports Menu (MAP1705) – A description of the type of reports that can be viewed is provided following Figure 55.

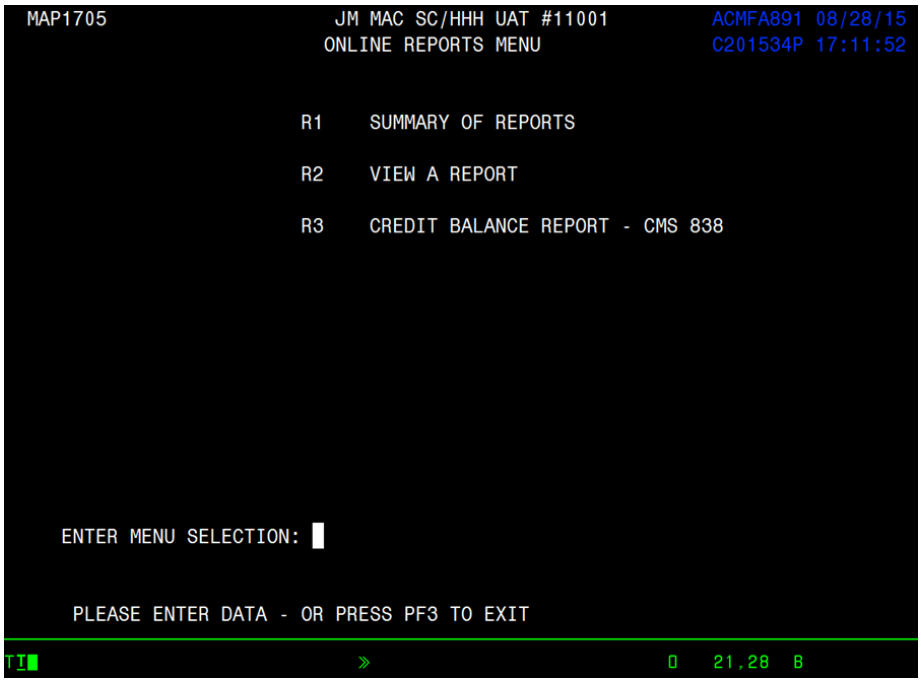


Figure 55 – Online Report Menu

The most frequently viewed provider reports are the Claims Returned to Provider Report (050); Pending, the Processed and Returned Claims Report (201); and the Errors on Initial Bills Report (316).

050 The **Claims Returned to Provider Report** lists the claims that are being returned to the provider for correction. The claims on the report are in status/location T B9997. The main difference between this report and the 201 is that it contains the description of the Reason Code(s) for the claim being returned.

201 The **Pending, Processed and Returned Claims Report** lists claims that are pending claims returned to the provider for correction and claims processed, but not necessarily shown as paid on a remittance advice. This report will exclude Medicare Choices, ESRD Managed Care and plan submitted HMO (Encounter) claims.

316 The **Errors on Initial Bills Report** is a listing, by provider, of errors received on new claims (claims which were entered into the system for the present cycle.)

From the Online Reports Menu (Figure 55), you can select R1 for a summary of reports from which you can select R2 to view a report by entering the report number (Figure 57) or R3 to view a credit balance report (Figure 58).

Online Reports Selection Inquiry R1 (MAP1671) – Field descriptions are provided in the table following Figure 56.

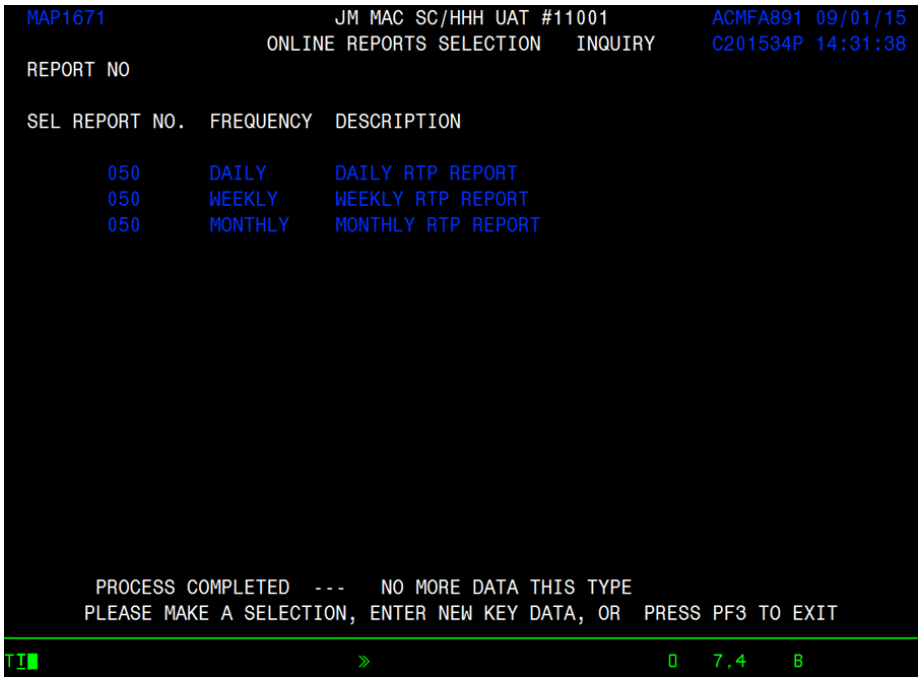


Figure 56 – R1-Summary of Reports, Online Reports Selection

Field Name	Description
REPORT NO	This field identifies the number of the report. Type in the desired report to view on-line.
SEL	The Selection field is used to select the report to be viewed. Type an 'S' before the desired report.
REPORT NO	Indicates the report number.
FREQUENCY	Reflects the frequency of the report – Daily, Weekly, or Monthly.
DESCRIPTION	Identifies the name or title of the report.

Report View Inquiry Screen R2 – Scroll Layout (MAP1661) – Field descriptions are provided in the table following Figure 57.

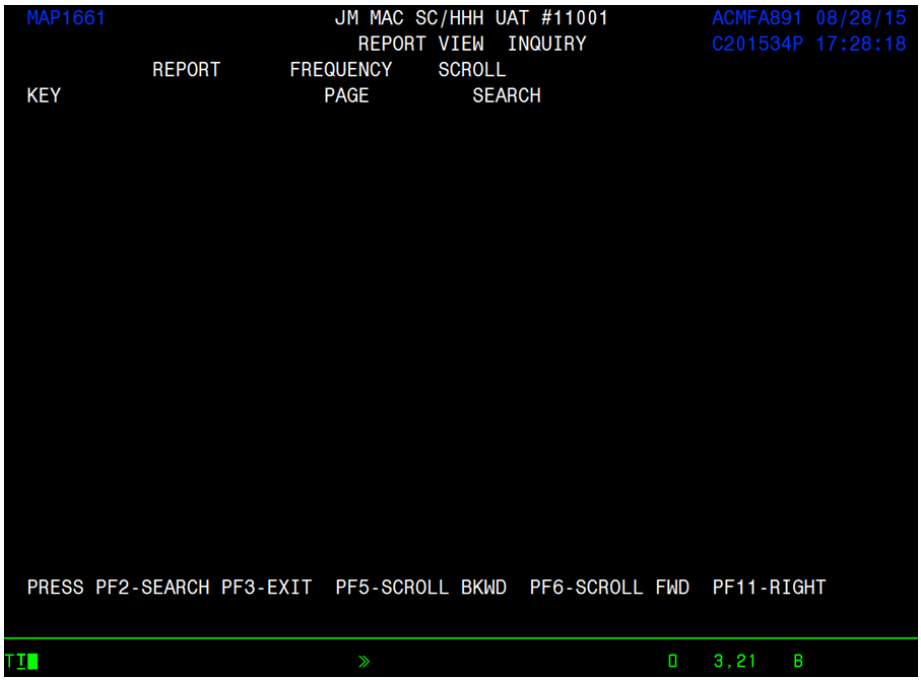


Figure 57 – R2-View A Report

Field Name	Description
REPORT	This field identifies the number of the report. Type in the desired report to view on-line.
FREQUENCY	Reflects how often the report is generated. Valid values are: 'D' = Daily 'W' = Weekly 'M' = Monthly.
SCROLL	This field is used to scroll to the left or right sides of the report.
KEY	This field reflects the key or sort field for the selected report.
PAGE	This field identifies the page number of the report being viewed.
SEARCH	This field searches for a specific field name or value.

Credit Balance Report R3- FORM 838 Inquiry Screen (MAP1B21) – Field descriptions are provided in the table following Figure 58.

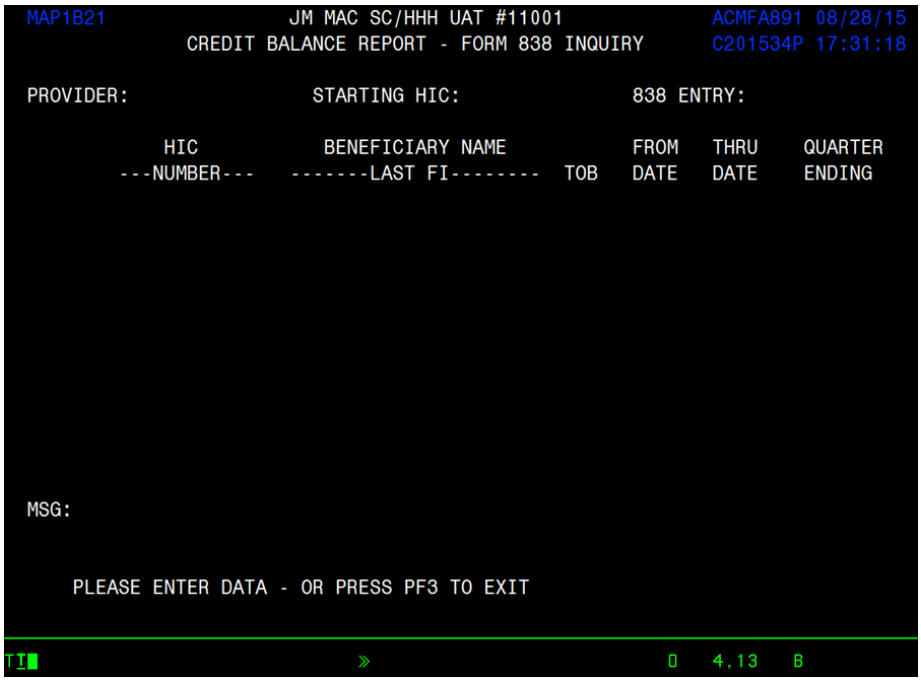


Figure 58 – R3-Credit Balance Report-Form 838 Inquiry

Field Name	Description
PROVIDER	This field displays the six-digit provider number issued by CMS.
STARTING HIC	This field identifies the beneficiary's Medicare number as shown on the Medicare card.
838 ENTRY	This field identifies the 838 Entry field. Valid values are: 'Y' = Yes 'N' = No **Note:** When this field is populated with a 'Y' the credit balance entry screen is displayed and allows the provider to enter a new record. **Note:** This option is not currently support by Palmetto GBA.
HIC NUMBER	This field identifies the beneficiary's Medicare number as shown the Medicare cared.
BENEFICIARY NAME LAST FI	This field displays the beneficiary's last name and the initial of the first name.
TOB	This field displays the Type of Bill for a particular period of care.
FROM DATE	Statement From Date – This field identifies the beginning date of service for the period included on the claim in MMDDYY format.
THRU DATE	Statement Through Date – This field identifies the ending date of service for the period included on the claim in MMDDYY format.
QUARTER ENDING	This field identifies the quarter ending date in CCYYMM format.

050 Report – Claims Returned to Provider

The Claims Returned to Provider Report lists the claims that are being returned to the Provider for correction. The claims on the report are in status/location T B9997. It is primarily used by providers who are not on DDE to identify the Reason Code(s) for the returned claims. This report includes the Reason Code(s) by number and narrative (Figures 59 and 60).

Report View Inquiry (MAP1661) Scroll Left View – Field descriptions are provided in the table following Figure 60.

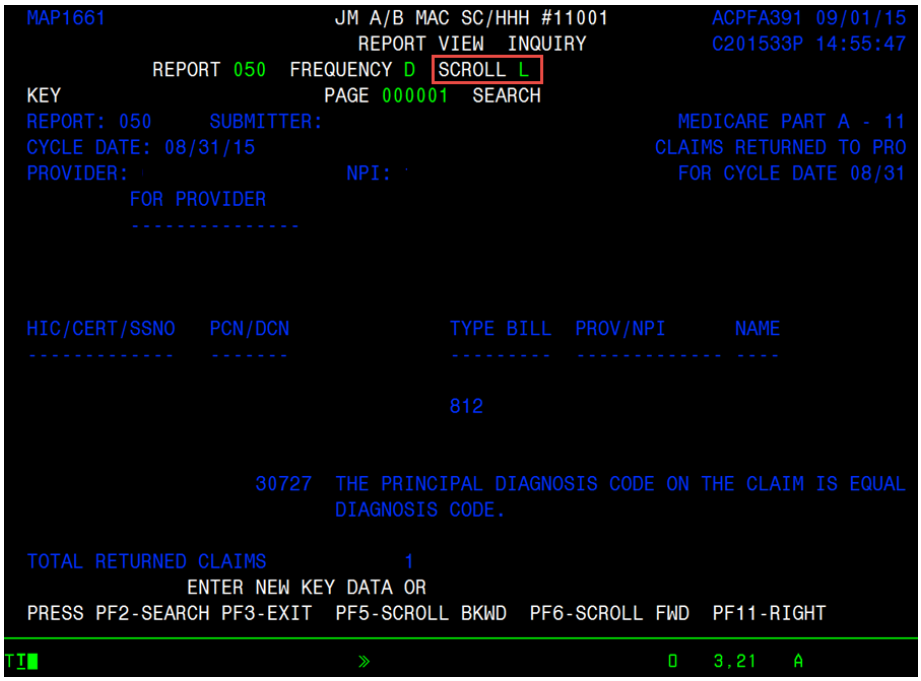


Figure 59 – 050 Claims Returned to Provider, Scroll Left View

Report View Inquiry (MAP1661) Scroll Right View – Field descriptions are provided in the table following Figure 60.

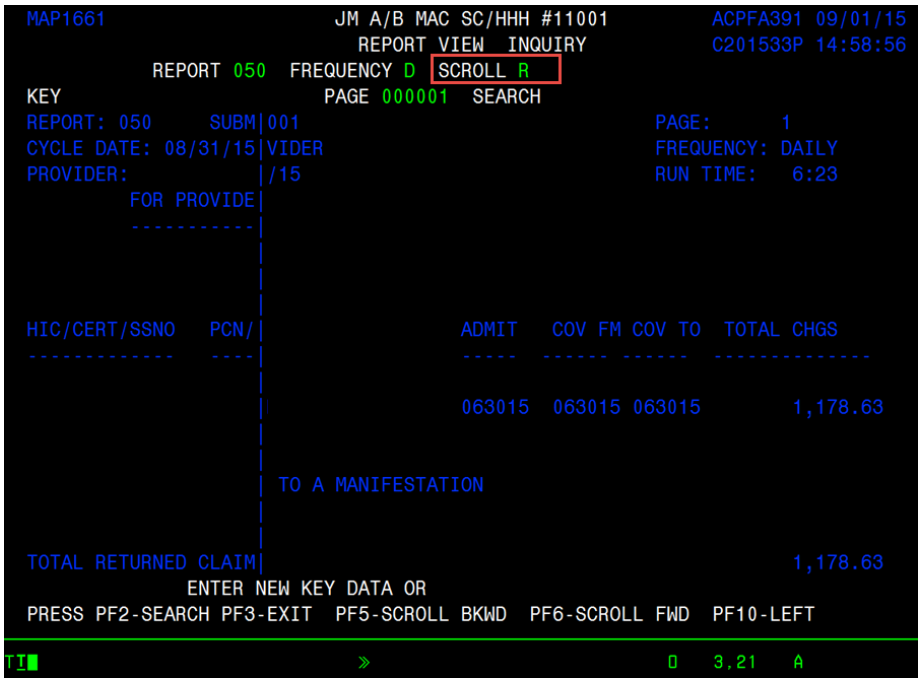


Figure 60 – 050 Claims Returned to Provider, Scroll Right View

Field Name	Description
REPORT	Identifies the unique number assigned to the Claims Returned to Provider report.
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
SEARCH	Allows searching for specific information contained in report fields by using [F2].
REPORT	Identifies the unique number assigned to the Claims Returned to Provider report.
PAGE	The specific page you are viewing within the report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
FREQUENCY	The frequency the report is run.
PROVIDER	Identifies the facility that rendered services for the claims being returned.
RUN TIME	The time of the production cycle that produced the reports.
FOR PROVIDER	The provider name and address for report remittance. This information is taken from the Provider File and is a total of 4 lines of 31 characters each.
HIC/CERT/SSNO	Identifies the Health Insurance Claim Number submitted by the provider for the beneficiary listed in the name field.
PCN/DCN	The Document Control Number identifies the returned claim.
TYPE OF BILL	Identifies the type of facility, type of care, source and frequency of this claim in a particular period of care.
PROVIDER	Identifies the facility listed on the claim.
NAME	Lists the beneficiary's last and first name as submitted by the provider of the patient who received the services.
ADMIT DATE	The date (in MMDDYY format) that the beneficiary was admitted for inpatient services or the beginning of the outpatient, home health or hospice services.
COV FM	Identifies the beginning date (in MMDDYY format) of services rendered to the beneficiary as indicated on the claim.
COV TO	Identifies the ending date of services rendered to the beneficiary as indicated on the claim.
TOTAL CHGS	Displays the total charges as submitted by the provider.
[REASON CODE AND NARRATIVE]	Displays the reason code(s) and narrative for the returned claim. There is a maximum of 150 occurrences for each reason code/narrative.
TOTAL RETURNED CLAIMS	The total number of reported claims being returned to the provider listed in the Provider field.
TOTAL RETURNED CHARGES	The total amount of charges for claims returned to the provider listed in the Provider field.

201 Report – Pended, Processed and Returned Claims

Figures 61 and 62 show the left view and right view of the Pended, Processed and Returned Claims report. The fields described in the table following the figures, display for Inpatient, Outpatient and Lab Pended Claims.

Report View Inquiry (MAP1661) Scroll Left View – Field descriptions are provided in the table following Figure 62.

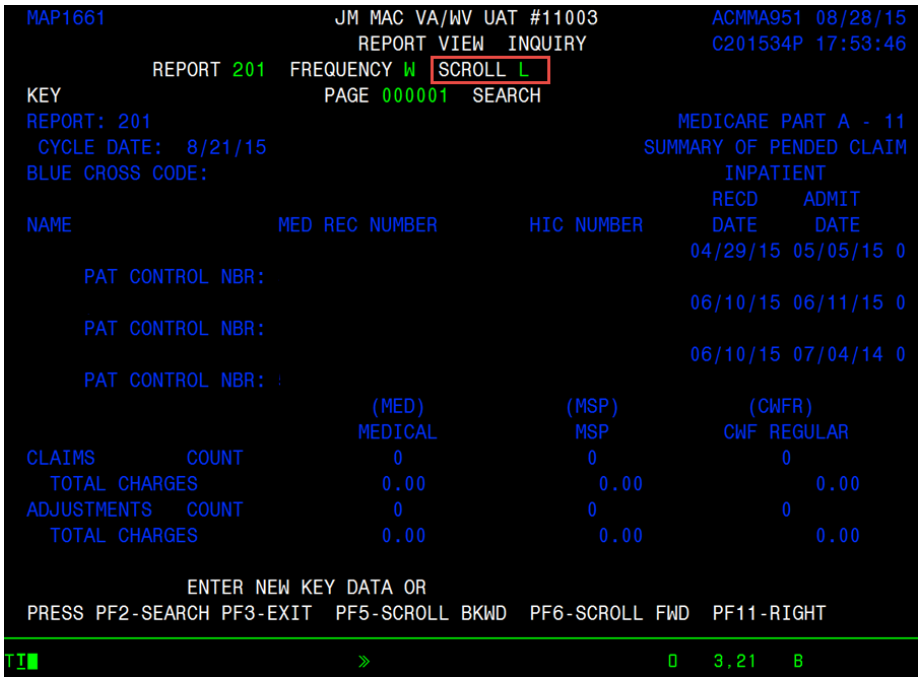


Figure 61 – 201 Pended, Processed and Returned Claims, Scroll Left View

Report View Inquiry (MAP1661) Scroll Right View – Field descriptions are provided in the table following Figure 62.

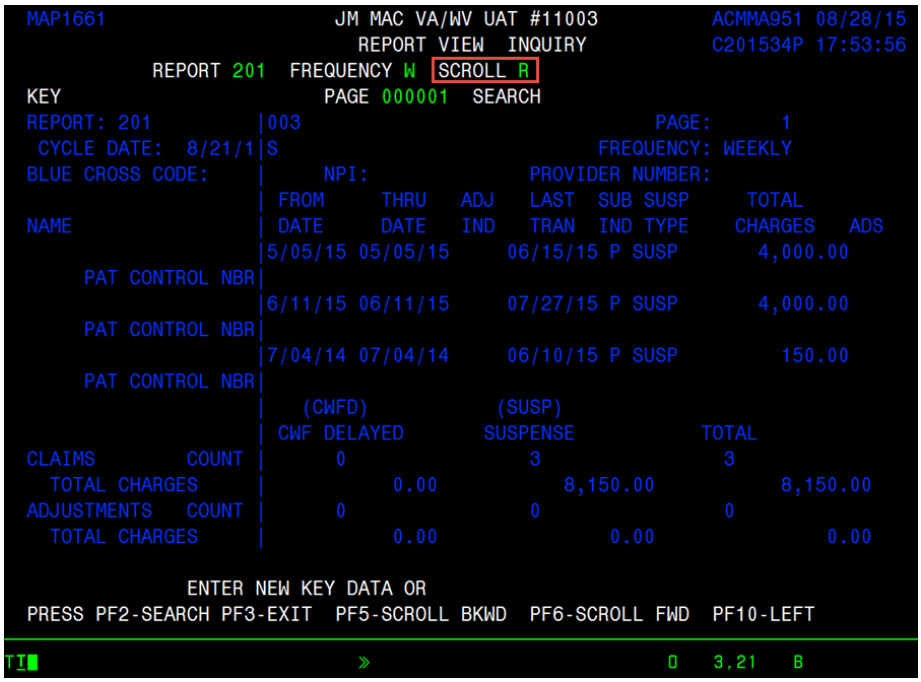


Figure 62 – 201 Pended, Processed and Returned Claims, Scroll Right View

Field Name	Description
Scroll Left	
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
FREQUENCY	The frequency under which the report is run. Valid values are D (Daily), W (Weekly) or M (Monthly).
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
PAGE	The specific page you are viewing within the report.
SEARCH	Allows searching for a particular type of claim or summary count information. Cycles through Inpatient/Outpatient/Lab/Other category.
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
TITLE OF REPORT	The right side of the Scroll Left screen shows the title of the report. This field is not labeled, but the Report title changes as the user cycles through the available Type of Bills (e.g., Pending, Processed or Returned).
BLUE CROSS CODE	The BCBS identification number assigned to a particular provider/facility.
TYPE OF CLAIM	The field is not titled, but the type of claim can be found under the report title on the right side of the Scroll Left screen. This field identifies the type of claim being reflected on the report (e.g., Inpatient/Outpatient/ Lab/Other).
NAME	The Beneficiary's Last Name/First Name.
MED REC NUMBER	The unique number assigned to the beneficiary at the medical facility.
HIC NUMBER	Identifies the unique Health Insurance Claim Number assigned to the beneficiary as shown on the Medicare card. This number is to be used on all correspondence and to facilitate the payment of claims.
RECD DATE	The date on which the Medicare contractor received the claim from the provider (in MMDDYY format).
ADMIT DATE	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care (in MMDDYY format).
PAT CONTROL NBR	Unique number assigned to the beneficiary at the medical facility.
(MED) MEDICAL	The total charges of the medical suspense category. Location code positions 2 & 3 - '50'.
(MSP) MSP	Medicare Secondary Payer identifies the category heading identifying counts, by Type of Bill, of adjustment records meeting the following criteria: Adjustment requester ID - 'H' (hospital) or 'F' (Fiscal Intermediary), and the adjustment reason code - 'AU', 'BL', 'DB', 'ES', 'LI', 'VA', 'WC' or 'WE'. Location code positions 2 & 3 - '80' or '85'.
(CWFR) CWF REGULAR	The total charges of the CWF category. Location code positions 2 & 3 - '90,' Location code position 4 **is not** 'B', 'F', 'J', 'L' or 'M'.
Scroll Right	
NPI	The National Provider Identifier (NPI) number of the provider rendering services to the beneficiary.
PROVIDER NUMBER	The Provider Number of the Medicare provider rendering services to the beneficiary.
FROM DATE	The beginning date of service for the period included on the claim (in MMDDYY format).
THRU DATE	The ending date of service for the period included on the claim (in MMDDYY format).
ADJ IND	Indicates if this record is an adjustment record. If the record is a debit or credit, this field will contain an asterisk, otherwise it will be blank.

Field Name	Description
LAST TRAN	Identifies the date of the most recent transaction on this claim (in MMDDYY format).
SUB IND	Identifies the mode of submission of the claim. If the UBC is a '7' or '8' (hard copy indicator), this will be a 'P' (paper claim); otherwise, it will contain an 'A' (automated claim).
SUSP TYPE	The suspense location where the claim resides within the system. Valid values are: MED = (Medical) Location code positions 2 & 3 is '50' MS = Location code positions 2 & 3 is '80' or '85' CWFR = Location code positions 2 & 3 is '90,' CWF = (Regular) Location code position 4 is not 'B', 'F', 'J', 'L' or 'M' CWFD = Location code positions 2 & 3 is '90,' CWF = (Delayed) Location code position 4 IS 'B', 'F', 'J', 'L' or 'M' SUSP = (Suspense) Any suspended claim (Status 'S') that does not fall into any of the categories listed above.
TOTAL CHARGES	Reflects total charges by beneficiary line item.
ADS	Additional Development System identifies if the claim has been to or currently resides in ADR. If Location code positions 2 & 3 have ever equaled 60, this field will contain a 'Y'; otherwise, it will be blank.
PAT CONTROL NBR	Unique number assigned to the beneficiary at the medical facility.
ADS REASON CODES	Identifies contains up to 10 5-digit reason codes requesting specific information from the provider on claims for which the ADS indicator is 'Y'.
(CWFD) CWF DELAYED	The total charges of the CWF category. Location code positions 2 & 3 - '90,' Location code position 4 **is** 'B,' 'F,' 'J,' 'L' or 'M'.
(SUSP) SUSPENSE	The total charges of all suspended claims (Status - 'S'), which do not fall into any of the other listed categories, e.g., MED, MSP, CWFR, CWFD.
CLAIMS COUNT	The total number of claims pending (not processed) at the end of the processing cycle for this Provider.
TOTAL CHARGES	The total charges by suspense category for pending claims or adjustments at the end of the processing cycle.
ADJUSTMENTS COUNT	Identifies by suspense category the total number of adjustments pending (not processed) at the end of the processing cycle for this Provider.
TOTAL CHARGES	Identifies by suspense category the total charges for pending claims or adjustments at the end of the processing cycle.

316 – Errors on Initial Bills

The Errors on Initial Bills report (Figures 63 and 64) lists (by Provider) errors received on new claims (claims entered into the system for the present cycle). The purpose of this report is to provide a monitoring mechanism for claims management and customer service to use in determining problem areas for Providers during their claim submission process.

Report View Inquiry (MAP1661) Scroll Left View – Field descriptions are provided in the table following Figure 64.

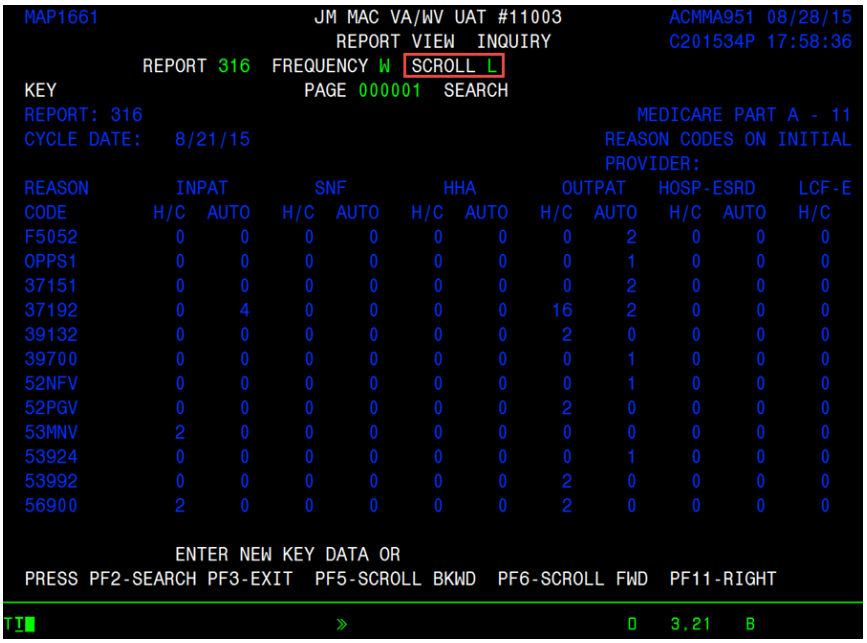


Figure 63 – 316 Errors on Initial Bills, Scroll Left View

Report View Inquiry (MAP1661) Scroll Right View – Field descriptions are provided in the table following Figure 64.

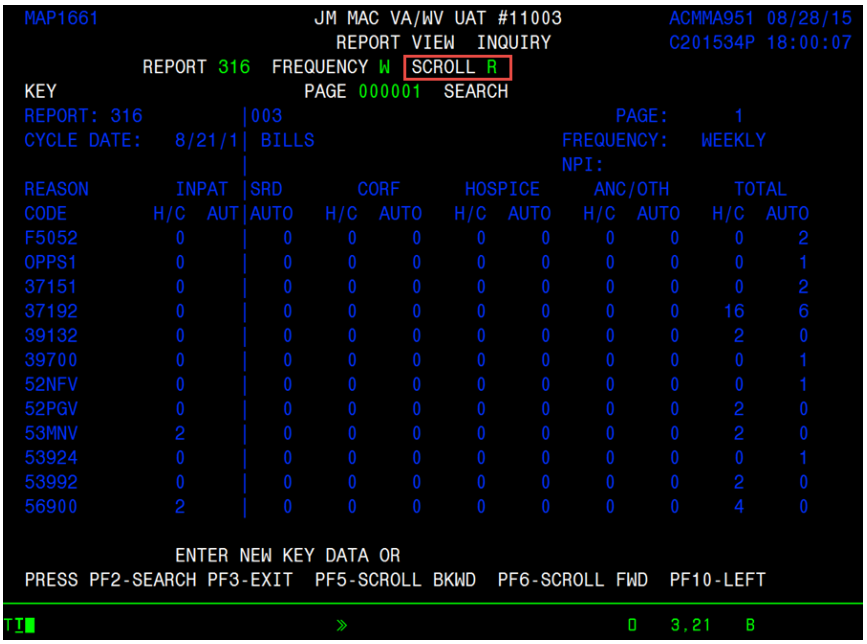


Figure 64 – 316 Errors on Initial Bills, Scroll Right View

Field Name	Description
Scroll Left View	
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
FREQUENCY	The frequency under which the report is run. Valid values are D (Daily), W (Weekly) or M (Monthly).

Field Name	Description
SCROLL	Indicates which "side" of the report you are viewing. Scroll L is the left side of the report and Scroll R is the right side. Press the [F11] and [F10] keys to move right and left.
KEY	The provider number.
PAGE	The specific page you are viewing within the report.
SEARCH	Allows searching for a particular type of claim or summary count information. Cycles through Inpatient/ Outpatient/Lab/Other category.
REPORT	The unique number assigned to the Summary of Pending Claims/Other report.
CYCLE DATE	Identifies the production cycle date (in MMDDYY format).
TITLE OF REPORT	This field is not labeled, but the report title changes as the user cycles through the available Type of Bills (e.g., Pending, Processed or Returned). It is located on the far right side of the screen.
PROVIDER	Identifies the Medicare Provider rendering services to the beneficiary.
REASON CODE	The reason code for a specific error reason condition, existing. The first position indicates the type and location of the reason code. Valid values include: 1 = CMS Unibill 2 = Reserved for future use 3 = Fiscal Intermediary Standard System 4 = File maintenance 5 = State (site) specific 6 = Post payment A-X = Miscellaneous errors Positions 2-5 indicate either a file or application error. If position 2 contains an alpha character, it is file related; otherwise, it is application related.
INPAT	Reflects all claims/adjustments with a Type of Bill 11X or 41X.
SNF	Reflects all SNF claims/adjustments with a Type of Bill 18X, 21X, 28X or 51X.
HHA	Reflects all HHA claims/adjustments with a Type of Bill 32X, 33X or 34X.
OUTPAT	Reflects all outpatient claims/adjustments with a Type of Bill 13X, 23X, 43X, 53X, 73X or 83X.
HOSP-ESRD	Reflects all Hospital End Stage Renal Disease claims with a Type of Bill 72X.
LCF-ESRD	Reflects all claims with a Long Term Care Facility End Stage Renal Disease Type of Bill 72X and a provider number greater than XX299 and less than XX2500 (XX represents the state code).
H/C	Claims by bill type, which are produced on paper and submitted to the Medicare contractor designated by a Uniform Bill Code less than 8.
AUTO	Claims by bill type, which are submitted to the Medicare contractor in an electronic mode, designated by a Uniform Bill Code greater than 7.
Right Scroll View	
CORF	Reflects all CORF claims/adjustments with a Type of Bill 75X.
HOSPICE	Reflects all Hospice claims/adjustments with a Type of Bill 81X or 82X.
ANC/OTHER	Reflects all Ancillary and Other claims with a Type of Bill 12X, 14X, 22X, 24X, 42X, 44X, 52X, 54X, 71X, 74X or 79X.
TOTAL	The total of all claims printed on this report for each specific Reason Code.
H/C	Claims by bill type, which are produced on paper and submitted to the Medicare contractor designated by a Uniform Bill Code less than 8.
AUTO	Claims by bill type, which are submitted to the Medicare contractor in an electronic mode, designated by a Uniform Bill Code greater than 7.

SECTION 8 – HEALTH INSURANCE QUERY ACCESS

The Health Insurance Query Access (HIQA) gives Medicare providers direct access to the CMS's CWF Host database. Providers may query a Beneficiary's Master Record. The beneficiary's record contains Medicare entitlement, hospice benefit information, Medicare Advantage (MA) Plan [also known as Medicare health maintenance organization (HMO)] information, and other payer information. Each beneficiary record is located at one of nine CWF Host sites.

CWF edits claims for validity, entitlement, remaining benefits, and deductible status. A reply from CWF will be returned the following day. The majority of claims will be accepted by CWF for remittance. Others will reject, open for recycle at a later date, or suspend for investigative action.

The objectives of the CWF are to provide:

- Complete beneficiary information to Medicare contractors such as Palmetto GBA
- Entitlement data
- Utilization data
- Claim history
- Information in a timely manner via an online process
- Accurate initial claims processing with—
    - Deductible access
    - Coinsurance access
    - Part A and Part B benefits paid comparison
    - Check editing prepayment (so contractor's approval equals CMS acceptance)
    - Duplicate payments prevention
    - Efficient implementation of future benefits and enhancements changes

Part A CWF Send Process

The Medicare contractor or satellite uses its best available information on beneficiary eligibility and remaining benefits to fully adjudicate claims. Every claim has been grouped, priced, and evaluated for Medicare Secondary Payer (MSP) involvement and has its final reimbursement (including interest when applicable) before it is sent. High Speed ***bulk data transfer*** transmits the Medicare contractor paid claim to the host for approval. Prior to ***SEND***, the Medicare contractor converts adjudicated claims from in-house format to CWF format. This is known as the ***best shot*** approach for bill payment. Claims awaiting CWF transmission reside in status/location **S B9000.**

Part A Response Process

Palmetto GBA maintains a holding file containing claims awaiting an initial CWF response (**S B9099**). No manual transaction can be made against these claims. Claims cannot be finally adjudicated until a definitive response is received from CWF, unless a manual function instructs the system to process the claim without being transferred to CWF. Responses aid in processing and proper adjudication of Medicare claims. The responses Palmetto GBA receives from the CWF are:

- CWF Edit Error codes that tell us a CWF response is ready to be worked (a 5-digit code appears in the lower left corner of the UB04 claim screen).
- A CWF Disposition Code, a 2-digit category or status of claim, that indicates:
    - Claim is approved
    - Claim is rejected
    - Claims will be retrieved from history
- Alert codes, CWF requests for investigation of overlapping benefits and eligibility status.
- Approved claims, Medicare contractor produced provider check and remittance advice.
- Rejected claims that require further investigation. Medicare contractor reviews these claims, makes corrections, and resubmits them to CWF.
- Recycled claims, which recycle automatically, back to CWF. The FISS status/location definitions are:

S B90_0 = 1st transmission
S B90_1 = 2nd transmission
S B90_2 = additional transmissions

CWF Host Sites

The Centers for Medicare & Medicaid Services maintains centralized files on each Medicare beneficiary with minimal eligibility and utilization data. Contractors query this file to process claims. **CWF** disperses the beneficiary files into **nine regional host sites**.

GL – Great Lakes	MA – Mid-Atlantic	SE – Southeast	GW – Great Western	
Illinois	Indiana	Alabama	Idaho	North Dakota
Michigan	Maryland	Mississippi	Iowa	Oregon
Minnesota	Ohio	North Carolina	Kansas	South Dakota
Wisconsin	Virginia	South Carolina	Missouri	Utah
	West Virginia	Tennessee	Montana	Washington
			Nebraska	Wyoming
PA – Pacific	**SO – South**	**KS – Keystone**	**NE – Northeast**	**SW – Southwest**
Alaska	Florida	Delaware	Connecticut	Arkansas
Arizona	Georgia	New Jersey	Maine	Colorado
California		New York	Massachusetts	Louisiana
Hawaii		Pennsylvania	New Hampshire	New Mexico
Nevada			Rhode Island	Oklahoma
			Vermont	Texas

HIQA Inquiry Screen

Once you have successfully logged onto the DDE system, from the blank screen, type HIQA to access the inquiry screen. The CWF beneficiary inquiry area will display (Figure 65). To access a beneficiary's CWF Master Record, enter information into this screen.

HIQA Inquiry Screen - Field definitions and completion requirements are provided in the table following Figure 65.

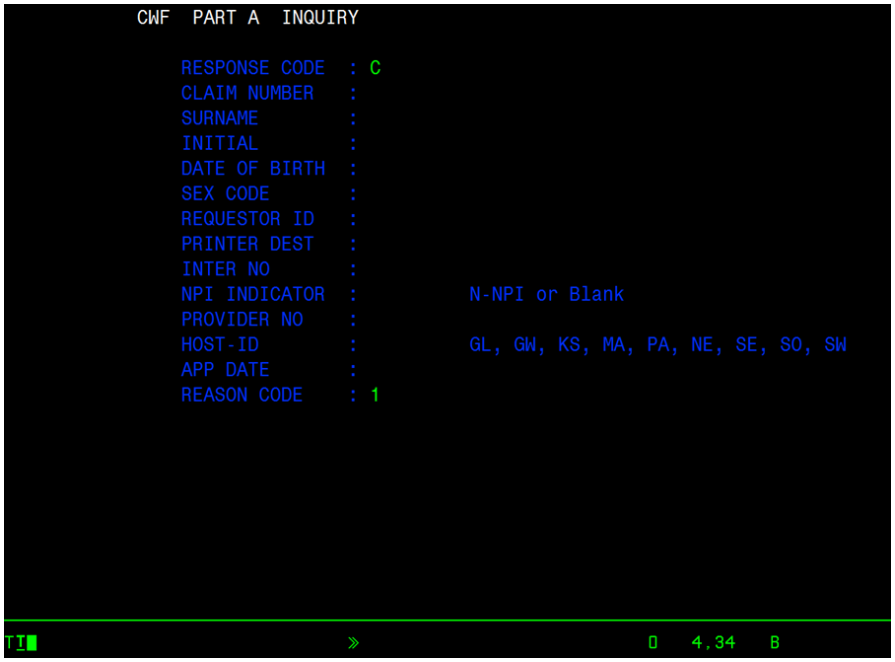


Figure 65 – CWF Beneficiary Inquiry Screen

Field Name	Description
RESPONSE CODE	Data in this field (a 'C' for Display on CRT) is automatically inserted by the system.
CLAIM NUMBER	Enter the beneficiary's Medicare number as shown on the Medicare card in this field.
SURNAME	Enter the first six (6) letters of the beneficiary's last name.
INITIAL	Enter the first initial of the beneficiary's first name.
DATE OF BIRTH	Enter the beneficiary's date of birth in MMDDCCYY format.
SEX CODE	Enter the beneficiary's sex. Valid values are: F = Female M = Male
REQUESTOR ID	Identifies person submitting the inquiry or person requesting printed output. Enter '1' in this field.
PRINTER DEST	Leave this field blank (system default printer). This field is for the Printer device that the response will be directed to if a 'P' or 'E' is typed in the Response Code field.
INTER NO	Identifies the Medicare contractor processing the claim. Enter one of the following for a beneficiary in Palmetto GBA's jurisdiction: ▪ 11201 = Part A South Carolina ▪ 11501 = Part A North Carolina ▪ 11301 = Part A Virginia ▪ 11401 = Part A West Virginia ▪ 11004 = Home health or hospice
PROVIDER NO	The six-digit number assigned by Medicare to the provider rendering medical service to the beneficiary.
HOST-ID	Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations: GL = Great Lakes MA = Middle Atlantic SE = Southeast GW = Great West PA = Pacific SO = South KS = Keystone NE = Northeast SW = Southwest
APP DATE	Date the beneficiary was admitted to the hospital in MMDDYY format. This field is not required. However, entering a date will allow for the most recent information to be provided.
REASON CODE	Indicates the reason for the inquiry. Valid codes are: 1 = Status Inquiry 2 = Inquiry relating to an admission A '1' is automatically inserted in this field by the system. Change this only if applicable.

HIQA Page 1 - Field descriptions for Page 1 of the HIQA screen are provided in the table following Figure 66.

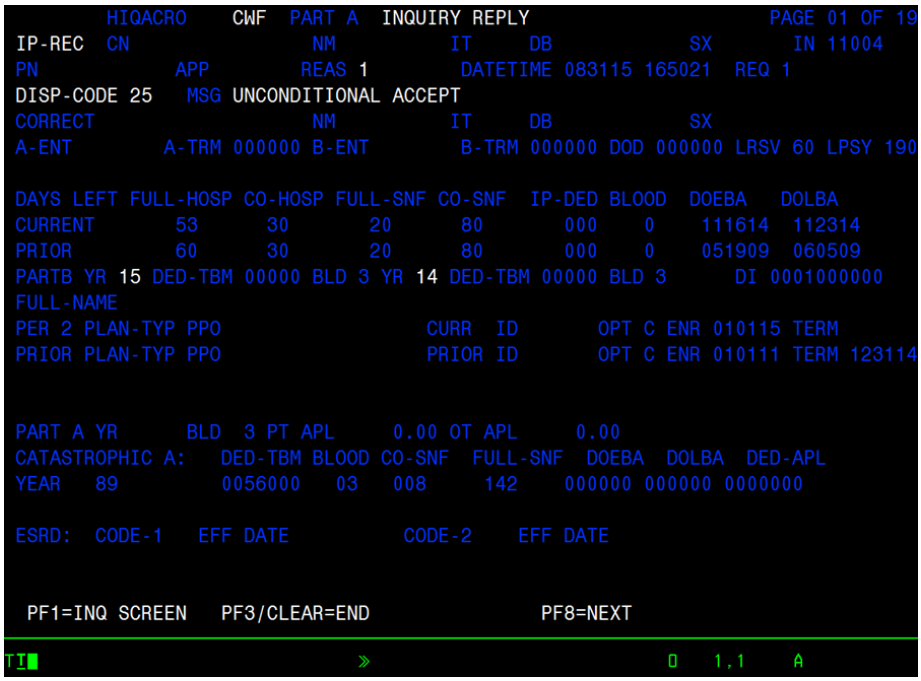


Figure 66 – CWF Part A Inquiry Reply Screen, Page 1

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
IN	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
PN	**Provider Number** – The facility's six-digit Medicare provider number.
APP	**Applicable Date** – Used for spell determination.
REAS	**Reason Code** – Indicates the reason for the inquiry that was entered on the initial inquiry screen (see Figure 65).
DATETIME	**Date and Time Stamp** – date and time of the inquiry in Julian date format.
REQ	**Requestor ID** – auto populates
DISP-CODE	**Disposition Code** – Indicates a condition on a CABLE response. Valid values are: 01 = Part A Inquiry approved 02 = Part A Inquiry approved 03 = Part A Inquiry rejected 20 = Qualified approval but may require further investigation 25 = Qualified approval 50 = Not in file 51 = Not in file on CMS batch system 52 = Master record housed at another HOST site 53 = Not in file in CMS but sent to CMS's alpha-reinstate 55 = Does not match a master record ER = Consistency edit reject UR = Utilization edit CR = A/B crossover edit CI = CICS processing problem SV = Security violation

Field Name	Description
MSG	**Message** – The verbiage pertaining to the disposition code.
CORRECT	**Correct Claim Number** – Displays the beneficiary's correct HIC number. If the HIC entered in the inquiry screen (Figure 66) is different than the number in this field, this is the number you will use to submit claims.
NM	**Corrected Name** – This field displays the beneficiary's correct name. The name in this field will be different only if the name entered in the inquiry (Figure 66) screen is not consistent with CMS's record.
IT	**Corrected Initial** – This field displays the beneficiary's correct initial of the first name. The initial in this field will be different only if the initial entered in the inquiry screen (Figure 66) is not consistent with CMS's record.
DB	**Corrected Date of Birth** – This field displays the beneficiary's correct date of birth. The date of birth in this field will be different only if the date of birth entered in the inquiry screen (Figure 66) is not consistent with CMS's record.
SX	**Corrected Sex Codes** – This field displays the beneficiary's correct sex. The sex code in this field will be different only if the sex code entered in the inquiry screen (Figure 66) is not consistent with CMS's record.
A-ENT	**Part A Entitlement** – Date of entitlement to Part A benefits in a MMDDYY format.
A-TRM	**Part A Termination** – Indicates date of termination of Part A entitlement, when applicable, in a MMDDYY format. Otherwise, this field will display all zeros.
B-ENT	**Part B Entitlement** – Date of entitlement to Part B benefits in MMDDYY format.
B-TRM	**Part B Termination** – Indicates date of termination of Part B entitlement, when applicable, in MMDDYY format. Otherwise, this field will display all zeros.
DOD	**Date of Death** – If the beneficiary is alive, the field will be all zeros.
LRSV	**Lifetime Reserve** – Shows the number of lifetime reserve days remaining.
LPSY	**Lifetime Psychiatric** – Shows the number of psychiatric days remaining.
DAYS LEFT FULL-HOSP	**Full Hospital Days Remaining** – Indicates the inpatient days remaining to be paid at full benefits.
CO-HOSP	**Coinsurance Hospital Days Remaining –** Indicates the impatient days remaining to be paid at coinsurance benefits.
FULL-SNF	**Full SNF Days Remaining** – Number of SNF days remaining to be paid at full benefits.
CO-SNF	**Coinsurance SNF Days Remaining** – Indicates the number of SNF days remaining to be paid at coinsurance benefits.
IP-DED	**Inpatient Deductible** – Amount of inpatient deductible remaining.
BLOOD	**Blood Deductible** – Number of pints blood deductible remaining.
DOEBA	**Date of Earliest Billing Action** – For this spell of illness.
DOLBA	**Date of Latest Billing Action** – For this spell of illness.
CURRENT	**Current Benefit Period** – applies to the remaining days, inpatient and blood deductible, DOEBA and DOLBA described above.
PRIOR	**Prior Benefit Period** – applies to the remaining days, inpatient and blood deductible, DOEBA and DOLBA described above.
PART B YR	**Most Recent Part B Year** – From the applicable date input field.
DED-TBM	**Deductible To Be Met –** Amount of the Part B cash deductible remaining to be met for the current year.
BLD	**Blood** – Part B blood deductible pints remaining to be met.
YR	**Year** – Next most recent Part B year.
DED-TBM	**Deductible to be Met**.
DI	**Data Indicators**. A. State Buy-In 0 = Does not apply 1 = State buy-in involved B. Alien Indicator 0 = Does not apply 1 = Alien nonpayment provision may apply C. Psychiatric Pre-entitlement

Field Name	Description
	1 = Psychiatric pre-entitlement reduction applied D. Reason for entitlement 0 = Normal 1 = Disability 2 = End Stage Renal Disease (ESRD) 3 = Has or had ESRD, but has current DIB 4 = Old age, but has or had ESRD 8 = Has or had ESRD and is covered under premium Part A 9 = Covered under premium Part A
FULL NAME	Beneficiary's full name.
PER	**Medicare Advantage (HMO) Period of Enrollment** – Code which indicates that the individual has had 1, 2, or 3 periods of enrollment in an HMO.
PLAN-TYP	**Medicare Advantage (HMO) Plan Type** – The type of plan the beneficiary has.
CURR ID	**Medicare Advantage (HMO) Identification Code** – Valid values are: 1 Position = H 2 & 3 Position = state code 4 & 5 Position = HMO number within the state
OPT	**Medicare Advantage (HMO) Option Code** – Describes the beneficiary's relationship with the HMO. Valid values are: 1 or 2 = HMO to process bills only for directly provided services and for service from providers with whom the HMO has effective arrangements. Palmetto GBA processes all other bills. C = HMO to process all bills.
ENR	**Medicare Advantage (HMO) Enrollment Date** – the date the beneficiary enrolled in the plan.
TERM HMO	**Medicare Advantage (HMO) Termination Date** – the date the beneficiary disenrolled from the plan.
PRIOR PLAN-TYP	**Prior Medicare Advantage (HMO) Plan type** – displays the prior type of plan the beneficiary was enrolled in.
PRIOR ID	**Prior Medicare Advantage (HMO) Plan ID** – displays the prior plan ID.
OPT	**Prior Medicare Advantage (HMO) Option Enrollment Code** – displays the option code from a prior plan.
ENR	**Prior Medicare Advantage (HMO) Enrollment Date** – date the beneficiary enrolled in prior plan.
TERM	**Prior Medicare Advantage (HMO) Termination Date** – date the beneficiary disenrolled from a prior plan.
PART A YR	Current Part A impatient stay data.
BLD	**Blood** –Blood deductible pints remaining to be met.
PT APL	**Physical Therapy** – The Part B physical therapy amount remaining for the most recent Medicare Part B benefit year.
OT APL	**Occupational Therapy** – The Medicare Part B occupational therapy amount remaining for the most recent part B benefit year.
CATASTROPHIC A YEAR	This field identifies the catastrophic trailer year.
DED-TBM	**Deductible to be Met** – The amount of the deductible that still has to be met.
CO-SNF	**Coinsurance SNF Days Remaining** – The number of SNF coinsurance days remaining in the period.
FULL-SNF	**Full SNF Days Remaining** – the number of full SNF days remaining in the period.
DOEBA	**Date of Earliest Billing Action** – For this spell of illness.
DOLBA	**Date of Latest Billing Action** – For this spell of illness.
DED-APL	**Deductible Applied** – The amount of deductible applied for this period.
ESRD	**End Stage Renal Disease**
CODE-1	**ESRD Code 1** – The beneficiary elected ESRD method 1, which means that the beneficiary will receive all supplies and equipment for home-dialysis from an ESRD facility.

Field Name	Description
EFF DATE	**Effective Date** – The beneficiary's ESRD effective date if he/she elected ESRD method 1.
CODE-2	**ESRD Code 2** – The beneficiary elected ESRD method 2, which means that the beneficiary will deal directly with one supplier for home dialysis supplies and equipment.
EFF DATE	**Effective Date** – The beneficiary's ESRD effective date if he/she elected ESRD method 2.

HIQA Page 2 - Field descriptions for Page 2 of the HIQA screen are provided in the table following Figure 67.

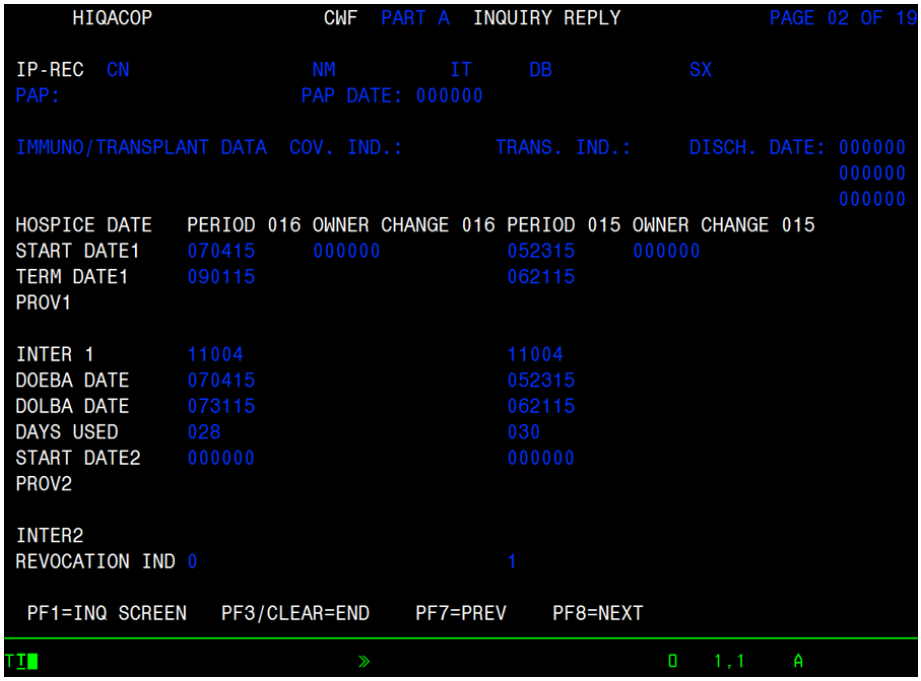


Figure 67 – CWF Part A Inquiry Reply Screen, Page 2

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
PAP	**PAP Risk Indicator** – Valid values are: 1 = Yes 2 = No
PAP DATE	Date PAP performed.
MAM	**Mammo Risk Indicator** – Valid values are: 1 = Yes 2 = No
TECH/PROF	**Mammography Technical Professional Component Date** – The date the technician/ professional claims were presented for x-rays used for mammography screening.
IMMUNO/ TRANSPLANT DATA COV IND	Indicates Medicare transplant surgery coverage available to the beneficiary. Valid values are: 1 = Space – No Coverage 2 = Transplant Coverage

Field Name	Description
TRANS IND	**Transplant Type Indicator** – Indicates the type of transplant surgery performed on the beneficiary. Valid values are: 1 = Allograft bone marrow - transplant from another person 2 = Autograft bone marrow - transplant from beneficiary H = Heart transplant K = Kidney transplant L = Liver transplant
DISCH DATE	**Discharge Date** – The date that the beneficiary was discharged from a hospital stay during which the indicated transplant occurred.
HOSPICE DATA	Indicates if a beneficiary has or had elected the Medicare hospice benefit.
START DATE 1	The elected start date of a beneficiary's hospice benefit period.
TERM DATE 1	The termination of the first hospice benefit period. May be listed as the end of the benefits for the hospice period indicated, or the revocation of hospice benefits.
PROV1	**First Provider** – First provider the beneficiary has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1	**First Intermediary Number** – Indicator as to the Medicare contractor that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period. Period 1 = 1-90 days Period 2 = 1-90 days Unlimited number of subsequent 60-day benefit periods
START DATE2	Lists second start date if a beneficiary elects to change hospices during a benefit period.
PROV2	Indicates the Second provider to bill hospice claims when the beneficiary chooses to change providers during a benefit period.
INTER2	**Second Intermediary Number** – Indicator as to the Medicare contractor that is processing the hospice claim if the beneficiary elects to change hospices during a benefit period that submits claims to a different contractor.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary has not revoked hospice benefits 1 = Beneficiary has revoked hospice benefits

HIQA Page 3 - Field descriptions for Page 3 of the HIQA screen are provided in the table following Figure 68.

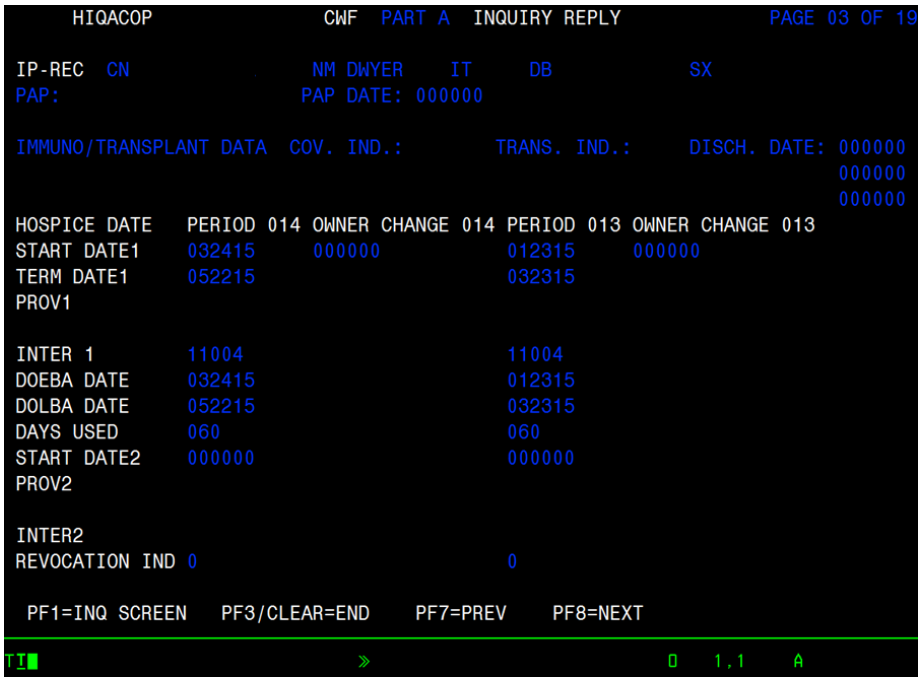


Figure 68 – CWF Part A Inquiry Reply Screen, Page 3

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
PAP	**PAP Risk Indicator** – Valid values are: 1 = Yes 2 = No
PAP DATE	Date PAP performed.
MAM	**Mammo Risk Indicator** – Valid values are: 1 = Yes 2 = No
TECH/PROF	This is the date that the technician/professional claims were presented for x-rays used for mammography screening.
IMMUNO/ TRANSPLANT DATA COV IND	Indicates Medicare transplant surgery coverage available to the beneficiary. Valid values are: 1 = Space – No Coverage 2 = Transplant Coverage
TRANS IND	**Transplant Type Indicator** – Indicates the type of transplant surgery performed on the beneficiary. Valid values are: 1 = Allograft bone marrow – transplant from another person 2 = Autograft bone marrow – transplant from beneficiary H = Heart transplant K = Kidney transplant L = Liver transplant
DISCH DATE	**Discharge Date** – The date the beneficiary was discharged from a hospital stay during which the indicated transplant occurred.
HOSPICE DATA	Indicates if the beneficiary elected the Medicare hospice benefit.
START DATE1	The elected start date of a beneficiary's period of hospice coverage.

Field Name	Description
TERM DATE 1	Indicates the termination of the first hospice benefit period. May be listed as the end of the benefits for the hospice period indicated, or the revocation of hospice benefits.
PROV1	**First Provider** – first provider the beneficiary has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1	**First Intermediary Number** – Indicator as to the Medicare contractor that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period.
START DATE2	Lists second start date if a beneficiary elects to change hospices during a benefit period.
PROV2	Indicates the Second provider to bill hospice claims when the beneficiary chooses to change providers during a benefit period.
INTER2	**Second Intermediary Number** – Indicator as to the Medicare contractor that is processing the hospice claim if the beneficiary elects to change hospices during a benefit period that submits claims to a different contractor.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary has not revoked hospice benefits. 1 = Beneficiary has revoked hospice benefits. 2 = Beneficiary has revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.

HIQA Page 4 - Field descriptions for Page 4 of the HIQA screen are provided in the table following Figure 69.

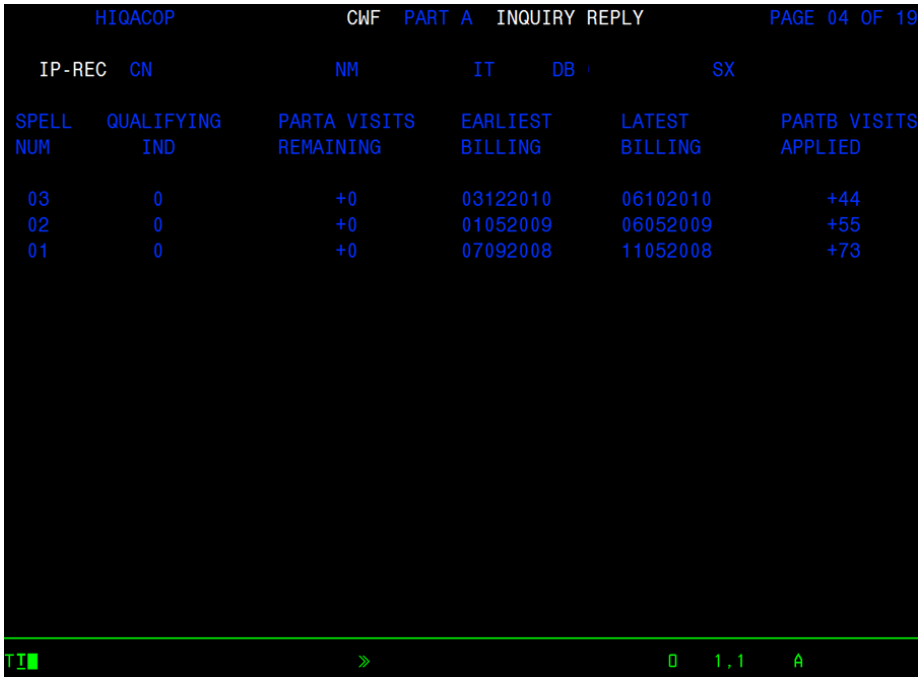


Figure 69 – CWF Part A Inquiry Reply Screen, Page 4

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
SPELL NUM	**Spell of Illness Number** – This number reflects the current home health spell of

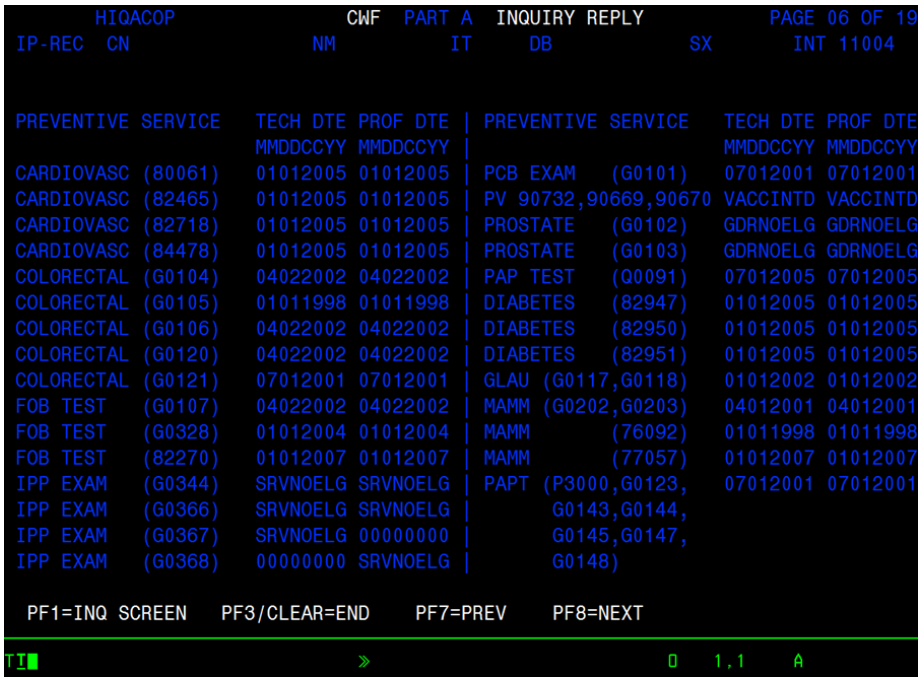
Field Name	Description
	illness.
QUALIFYING IND	**Qualifying Stay Indicator** – This is a numeric field used to identify a qualifying A/B split hospitalization. Valid values are: 0 = No 1 = Yes
PART A VISITS REMAINING	The number of Part A visits remaining in the benefit period. Medicare Part A pays for the first 100 visits if a patient has a qualifying hospital stay, and if a patient is admitted to home health within 14 days of discharge. Medicare Part B pays for the remaining visits. In addition, Medicare Part B pays for all visits if there is no qualifying hospital stay (the patient must have Medicare Part B for Part B to reimburse for the services). If a beneficiary has Medicare Part A only, then Part A will pay for all of their services.
EARLIEST BILLING	The date of the first bill submitted during the benefit period.
LATEST BILLING	The date of last bill submitted during the benefit period.
PARTB VISITS APPLIED	The number of visits reimbursed by Medicare Part B.

HIQA Page 5 - Field descriptions for Page 5 of the HIQA screen are provided in the table following Figure 70.

Figure 70 – CWF Part A Inquiry Reply Screen, Page 5

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
EPISODE START	The start date of a home health episode.
EPISODE END	The end date of a home health episode.
DOEBA	**Date of Earliest Billing Action** - the first service date of the HHPPS period.
DOLBA	**Date of Last Billing Action** - the last service date of the HHPPS period.

HIQA Pages 6 and 7 - Field descriptions for Page6 and 7 of the HIQA screens are provided in the table following Figure 72.



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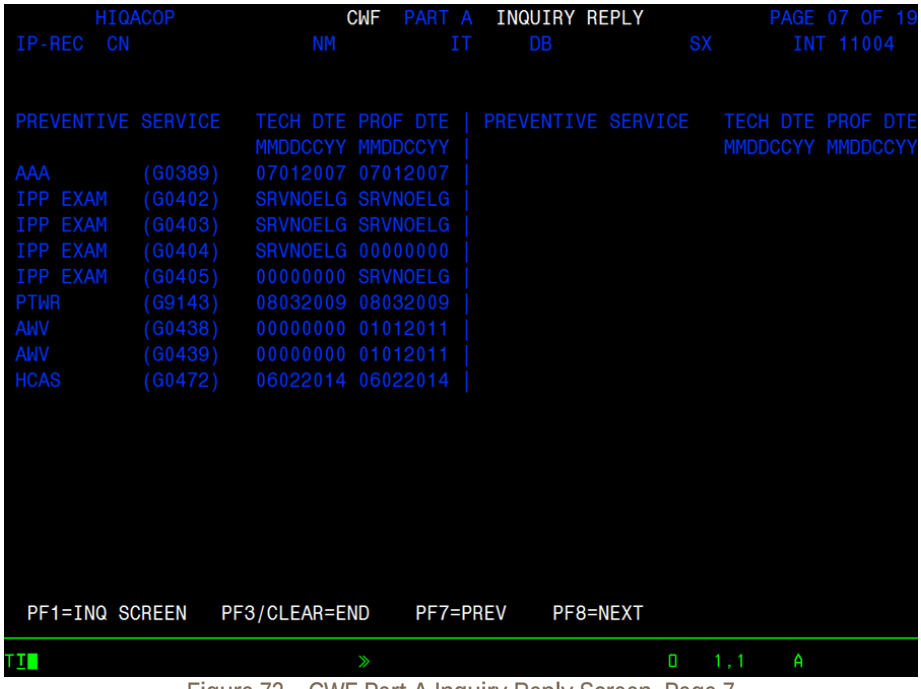
       HIQACOP              CWF  PART A  INQUIRY REPLY          PAGE 06 OF 19
 IP-REC  CN               NM          IT     DB            SX       INT 11004


 PREVENTIVE SERVICE   TECH DTE PROF DTE | PREVENTIVE SERVICE   TECH DTE PROF DTE
                      MMDDCCYY MMDDCCYY |                      MMDDCCYY MMDDCCYY
 CARDIOVASC (80061)   01012005 01012005 | PCB EXAM   (G0101)   07012001 07012001
 CARDIOVASC (82465)   01012005 01012005 | PV 90732,90669,90670 VACCINTD VACCINTD
 CARDIOVASC (82718)   01012005 01012005 | PROSTATE   (G0102)   GDRNOELG GDRNOELG
 CARDIOVASC (84478)   01012005 01012005 | PROSTATE   (G0103)   GDRNOELG GDRNOELG
 COLORECTAL (G0104)   04022002 04022002 | PAP TEST   (Q0091)   07012005 07012005
 COLORECTAL (G0105)   01011998 01011998 | DIABETES   (82947)   01012005 01012005
 COLORECTAL (G0106)   04022002 04022002 | DIABETES   (82950)   01012005 01012005
 COLORECTAL (G0120)   04022002 04022002 | DIABETES   (82951)   01012005 01012005
 COLORECTAL (G0121)   07012001 07012001 | GLAU (G0117,G0118)   01012002 01012002
 FOB TEST   (G0107)   04022002 04022002 | MAMM (G0202,G0203)   04012001 04012001
 FOB TEST   (G0328)   01012004 01012004 | MAMM       (76092)   01011998 01011998
 FOB TEST   (82270)   01012007 01012007 | MAMM       (77057)   01012007 01012007
 IPP EXAM   (G0344)   SRVNOELG SRVNOELG | PAPT (P3000,G0123,   07012001 07012001
 IPP EXAM   (G0366)   SRVNOELG SRVNOELG |       G0143,G0144,
 IPP EXAM   (G0367)   SRVNOELG 00000000 |       G0145,G0147,
 IPP EXAM   (G0368)   00000000 SRVNOELG |       G0148)

  PF1=INQ SCREEN    PF3/CLEAR=END     PF7=PREV     PF8=NEXT

TI                              »                        0   1,1    A
```

Figure 71 – CWF Part A Inquiry Reply Screen, Page 6



```
       HIQACOP              CWF  PART A  INQUIRY REPLY          PAGE 07 OF 19
 IP-REC  CN               NM          IT     DB            SX       INT 11004


 PREVENTIVE SERVICE   TECH DTE PROF DTE | PREVENTIVE SERVICE   TECH DTE PROF DTE
                      MMDDCCYY MMDDCCYY |                      MMDDCCYY MMDDCCYY
 AAA        (G0389)   07012007 07012007 |
 IPP EXAM   (G0402)   SRVNOELG SRVNOELG |
 IPP EXAM   (G0403)   SRVNOELG SRVNOELG |
 IPP EXAM   (G0404)   SRVNOELG 00000000 |
 IPP EXAM   (G0405)   00000000 SRVNOELG |
 PTWR       (G9143)   08032009 08032009 |
 AWV        (G0438)   00000000 01012011 |
 AWV        (G0439)   00000000 01012011 |
 HCAS       (G0472)   06022014 06022014 |

  PF1=INQ SCREEN    PF3/CLEAR=END     PF7=PREV     PF8=NEXT

TI                              »                        0   1,1    A
```

Figure 72 – CWF Part A Inquiry Reply Screen, Page 7

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.

Field Name	Description
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Preventive Services	
CARDIOVASC	Cardiovascular
COLORECTAL	Colorectal
FOB TEST	Fecal Occult Blood Test
IPP EXAM	Initial Preventive Physical Examination
PCB EXAM	Pelvic and Clinical Breast Examination
PPV	Pneumococcal Pneumonia Vaccine
PROSTATE	Prostate
PAP TEST	Pap Smear Test
DIABETES	Diabetes
GLAU	Glaucoma
MAMM	Mammography
PAPT	Pap Smear Test
AAA	Abdominal Aortic Aneurysm
AWV	Annual Wellness Visit
IPP EXAM	Initial Preventive Physical Examination
BLANK	Healthcare Common Procedure Coding System (HCPCS) code for the preventive service
TECH DTE	Next eligible technical date for the preventive service listed
PROF DTE	Next eligible professional date for the preventive service listed

The TECH DTE and PROF DTE may show abbreviations in the MMDDYYYY field. Some common abbreviations that may occur include:

- AGENOELG – Beneficiary not eligible due to age
- GDRNOELG – Beneficiary not eligible due to gender
- NOPTBENT – Beneficiary not entitled to Part B
- 00000000 – Service not applicable
- SRVNOELG – Beneficiary not eligible for the service
- VACCINTD – Beneficiary already vaccinated
- RECEIVED – Beneficiary already received the service
- DODNOELG – Beneficiary not eligible due to date of death

HIQA Page 8 - Field descriptions for Page 8 of the HIQA screen are provided in the table following Figure 73.

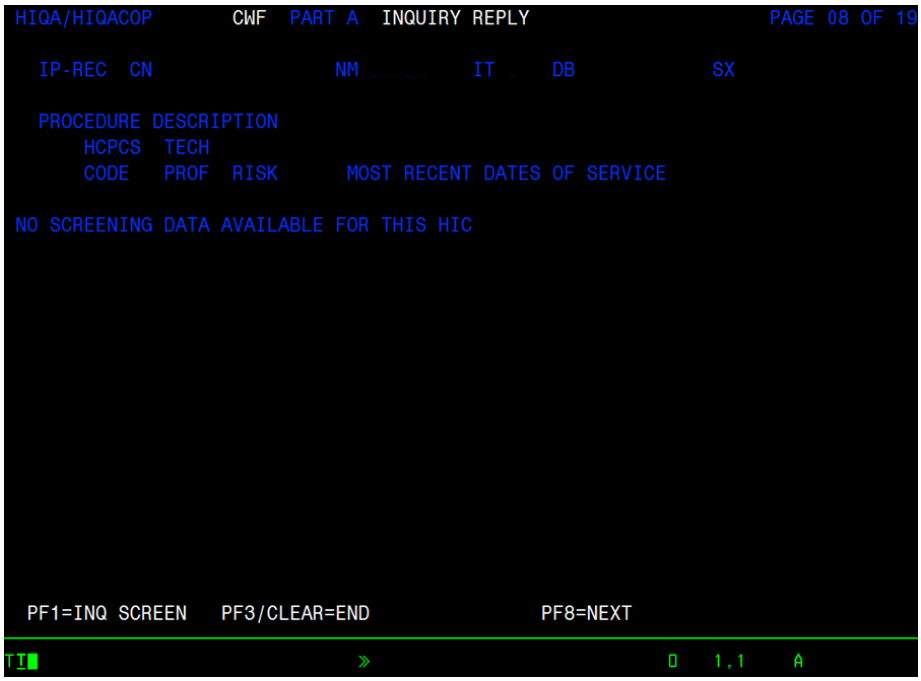


Figure 73 – CWF Part A Inquiry Reply Screen, Page 8

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
PROCEDURE DESCRIPTION	Technical and professional description of the HCPCS/procedure
HCPCS CODE	Healthcare Common Procedure Coding System (HCPCS) code of the procedure
TECH PROF	Technical or professional indicator
RISK	Not Used
MOST RECENT DATES OF SERVICE	Shows the three most recent dates of service for the HCPCS Technical and Professional codes.

HIQA Page 9 - Field descriptions for Page 9 of the HIQA screen are provided in the table following Figure 74.

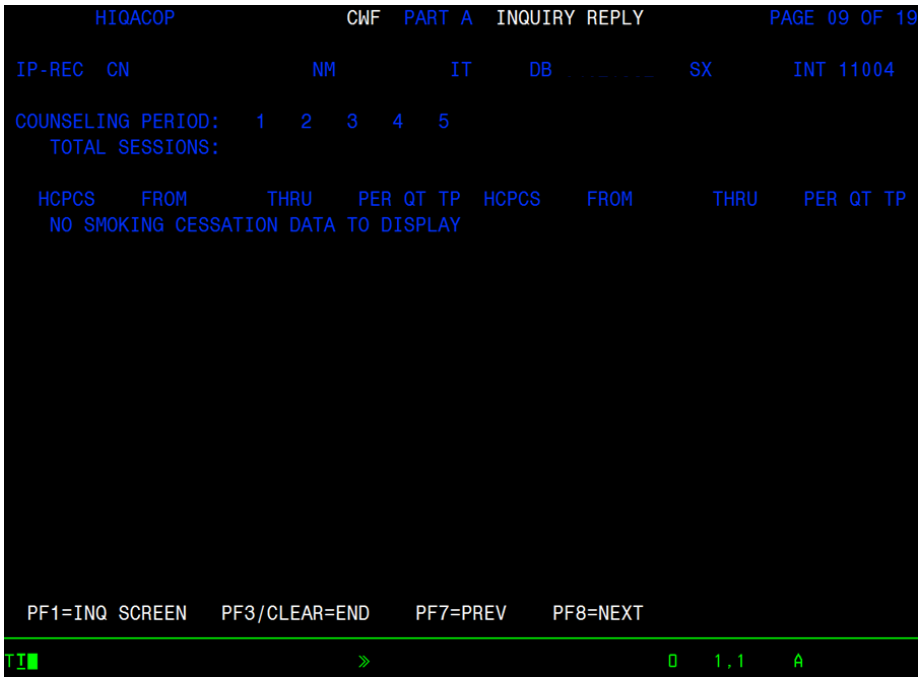


Figure 74 – CWF Part A Inquiry Reply Screen, Page 9

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
COUNSELING PERIOD	Identifies up to five years of counseling data. Valid values include: '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
TOTAL SESSIONS	Identifies the number of sessions billed for the beneficiary.
HCPCS	HCPCS Code
FROM	From date of claim
THRU	Through date of claim
PER	Identifies up to five years of counseling data. Valid values include '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
QT	**Quantity** – The number of services billed for each date.
TP	Claim type

HIQA Page 10 - Field descriptions for Page 10 of the HIQA screen are provided in the table following Figure 75.

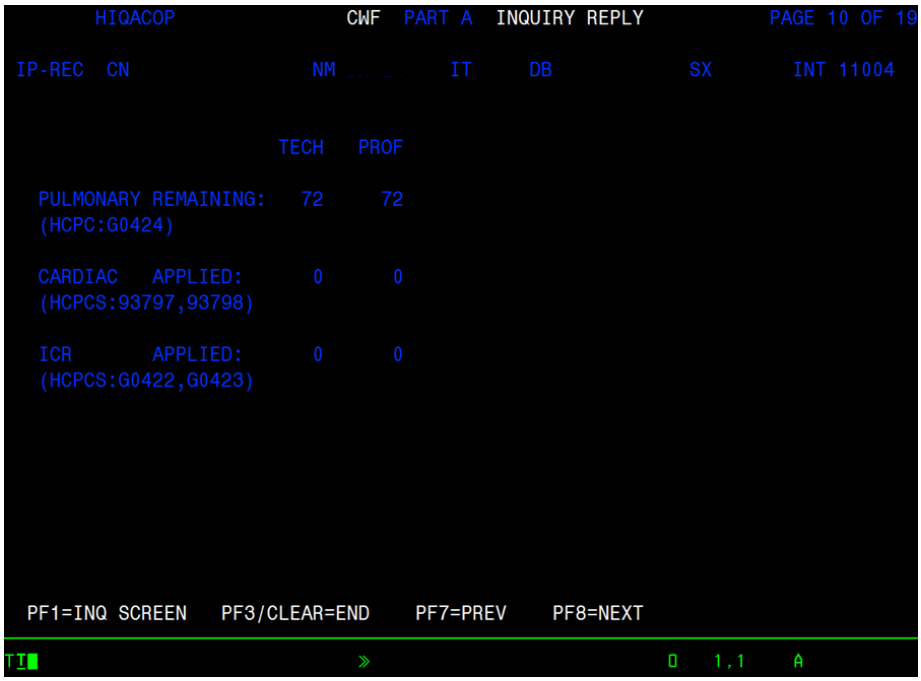


Figure 75 – CWF Part A Inquiry Reply Screen, Page 10

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TECH	Technical
PROF	Professional
PULMONARY REMAINING	The total number of technical and professional Pulmonary Rehabilitation services remaining.
CARDIAC APPLIED	The total number of professional and technical Cardiac Rehabilitation services used.
ICR APPLIED	The total number of professional and technical Intensive Cardiac Rehabilitation services used.

HIQA Page 11 - Field descriptions for Page 11 of the HIQA screen are provided in the table following Figure 76.

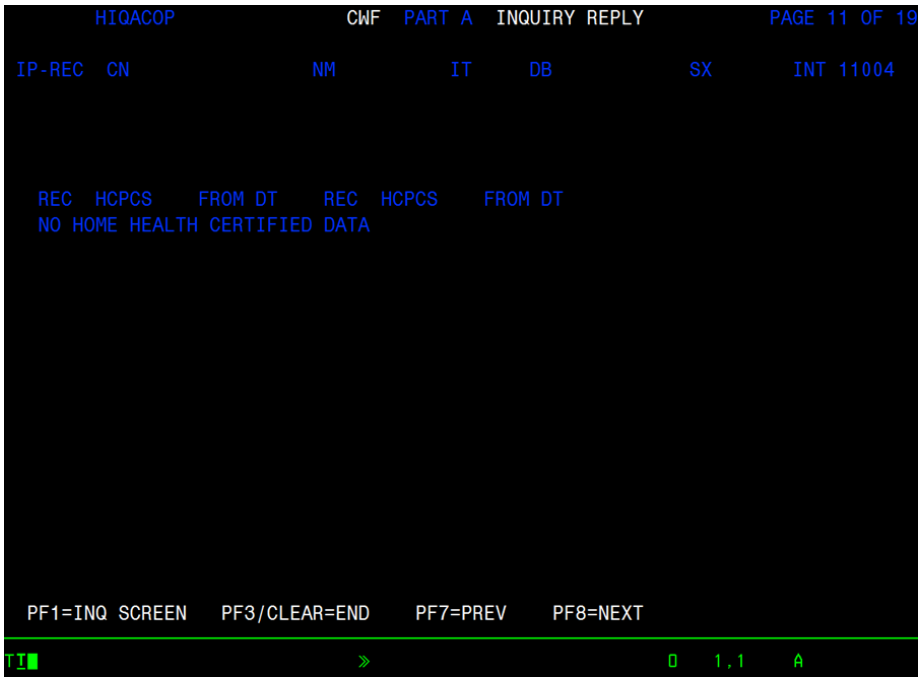


Figure 76 – CWF Part A Inquiry Reply Screen, Page 11

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
REC HCPCS	**Record HCPCS** – Identifies the HCPCS filed.
FROM DT	**From Date** – The home health certification from date.

HIQA Page 12 - Field descriptions for Page 12 of the HIQA screen are provided in the table following Figure 77.

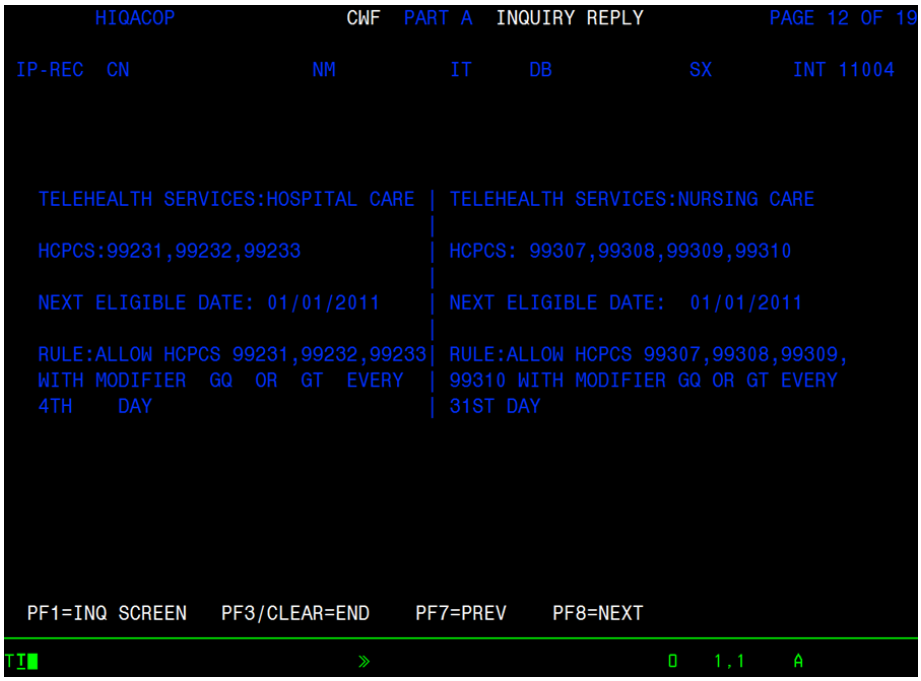


Figure 77 – CWF Part A Inquiry Reply Screen, Page 12

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TELEHEALTH SERVICES: HOSPITAL CARE	Telehealth services rendered under hospital care.
TELEHEALTH SERVICES: NURSING CARE	Telehealth services rendered under nursing care.
HCPCS	The HCPCS codes billed.
NEXT ELIGIBILE DATE	The beneficiary's next eligible date for services.
RULE	The Allowed HCPCS, with modifier and how often.

HIQA Page 13 - Field descriptions for Page 13 of the HIQA screen are provided in the table following Figure 78.

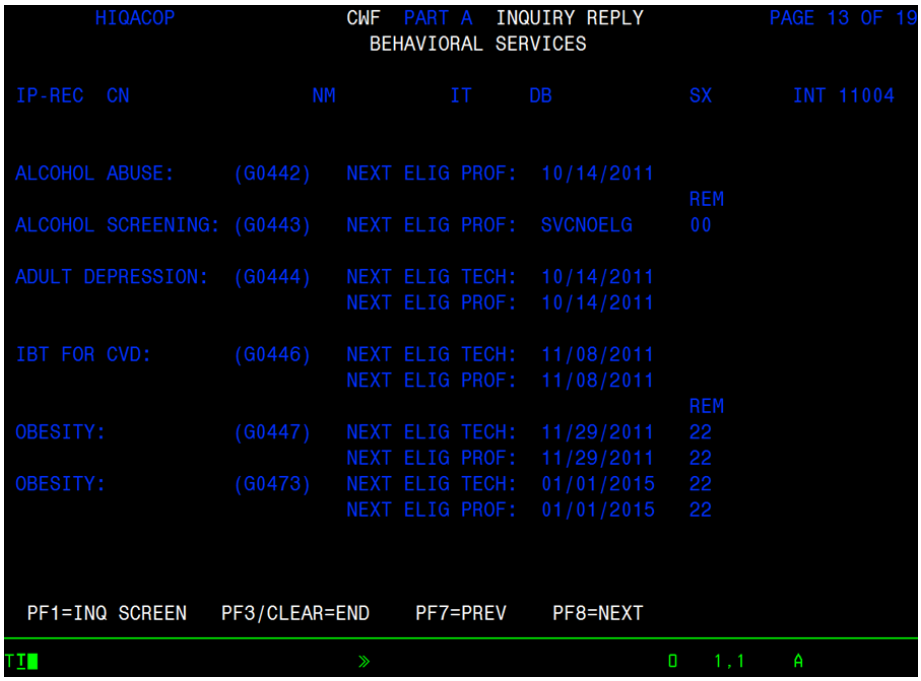


Figure 78 – CWF Part A Inquiry Reply Screen, Page 13

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
ALCOHOL ABUSE	This field identifies the HCPCS code billed for Alcohol abuse screening.
ALCOHOL SCREENING	This field identifies the HCPCS code billed for a face-to-face behavioral counseling for alcohol misuse.
ADULT DEPRESSION	This field identifies the HCPCS code billed for the annual depression screening.
IBT FOR CVD OBESITY	This field identifies the HCPCS code billed for **Intensive Behavioral Therapy (IBT) for Covered (CVD) Obesity**.
NEXT ELIG TECH	**Next Eligible Technical Date** – This field identifies the next date the patient is eligible for the technical component of the screening.
NEXT ELIG PROF	**Next Eligible Professional Date** – This field identifies the next date the patient is eligible for the professional component of the screening.

HIQA Page 14 - Field descriptions for Page 14 of the HIQA screen are provided in the table following Figure 79.

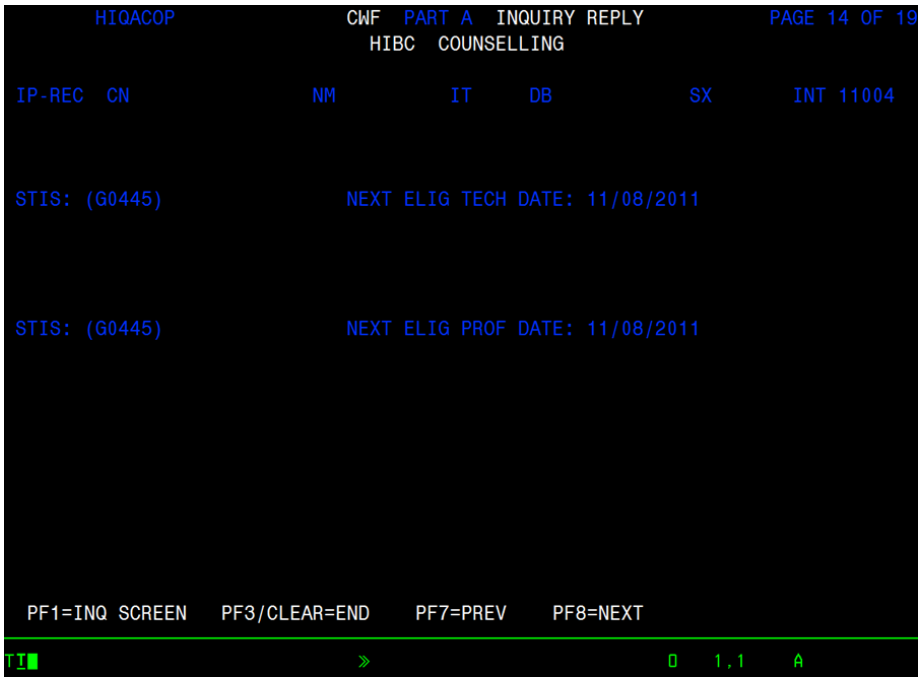


Figure 79 – CWF Part A Inquiry Reply Screen, Page 14

Field Name	Description
High Intensity Behavioral Counseling (HIBC) Counseling	
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
STIS	**Sexually Transmitted Infections** – This field identifies the codes billed for STI screening.
NEXT ELIG TECH DATE	**Next Eligible Technical Date** – This field identifies the next date the patient is eligible for the technical component of the screening.
NEXT ELIG PROF DATE	**Next Eligible Professional Date** – This field identifies the next date the patient is eligible for the professional component of the screening.

HIQA Page 15 - Field descriptions for Page 15 of the HIQA screen are provided in the table following Figure 80.

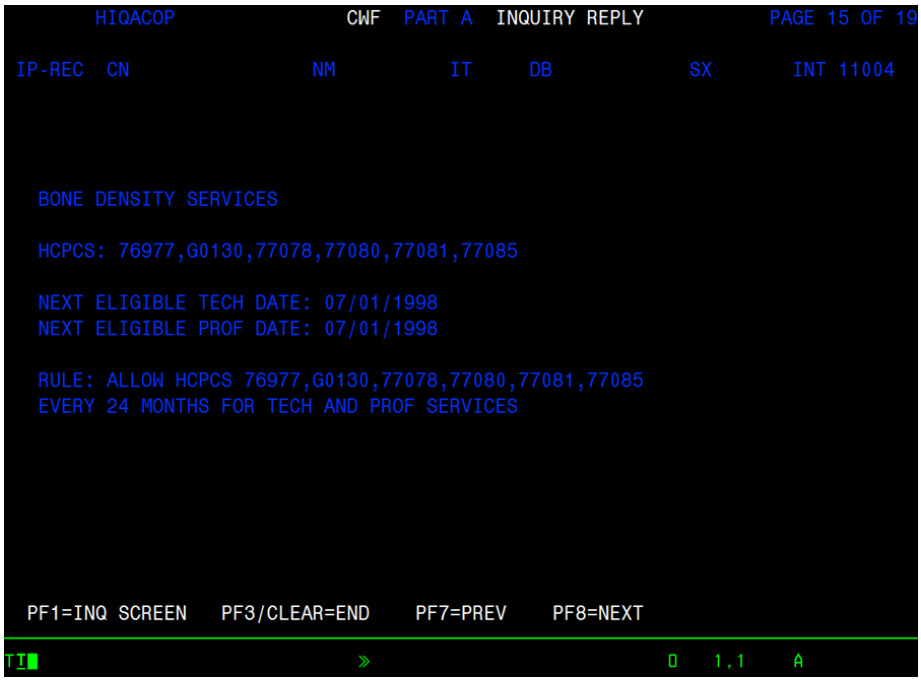


Figure 80 – CWF Part A Inquiry Reply Screen, Page 15

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Bone Density Services	
HCPCS	This field identifies the HCPCS codes billed for the bone density services.
NEXT ELIGIBLE TECH DATE	This field reflects the next eligible date for the technical component of the bone density services.
NEXT ELIGIBLE PROF DATE	This field reflects the next eligible date for the professional component of the bone density services.
RULE	This field identifies the allowable HCPCS codes and how often for the bone density services.

HIQA Page 16 - Field descriptions for Page 16 of the HIQA screen are provided in the table following Figure 81.

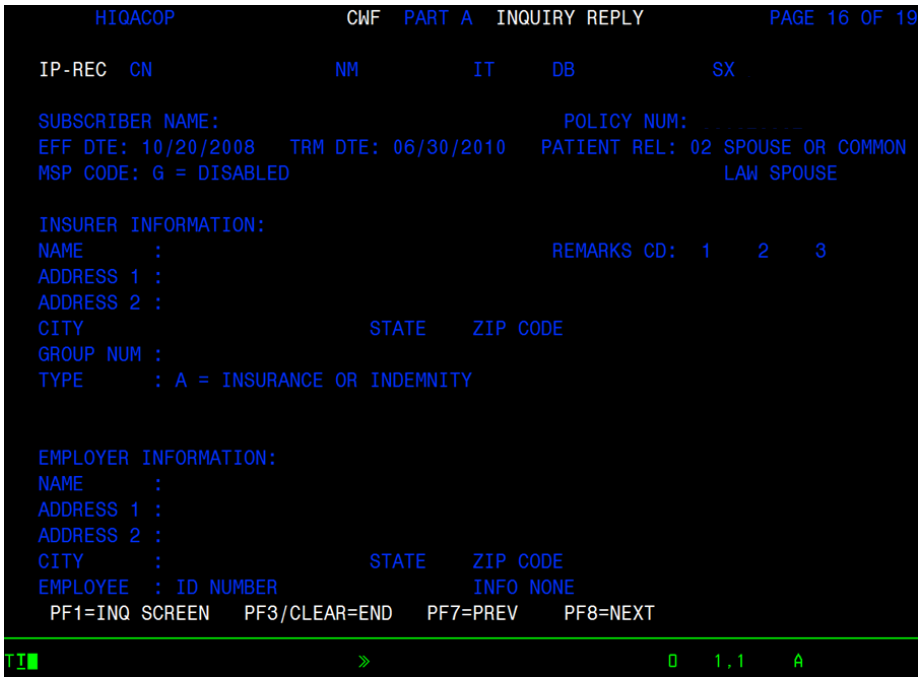


Figure 81 – CWF Part A Inquiry Reply Screen, Page 16

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
SUBSCRIBER NAME:	This field identifies the name of the policy holder of the primary plan.
POLICY NUM:	This field identifies the policy number of the primary plan.
EFF DATE	**Effective Date** – This field identifies the date the coverage of the primary plan began.
TRM DTE	**Termination Date** – This field identifies the date the coverage of the primary plan ended or was terminated.
PATIENT REL	**Patient Relationship** – This field identifies the relationship of the subscriber to the beneficiary.
MSP CODE	**Medicare Secondary Payer Source Code** – This field identifies the MSP source code (e.g., disability, working aged, liability, etc.).
Insurer Information	
NAME	This field identifies the name of the primary insurer.
REMARKS CODE	This field identifies information needed by the contractor to assist in additional development. Up to three remarks codes may be displayed.
ADDRESS 1	This field provides the address of the primary insurer.
ADDRESS 2	This field provides the address of the primary insurer.
CITY STATE ZIP CODE	This field identifies the City, State, and ZIP code of the primary insurer.
GROUP NUM	**Insurer Group Number** – This field identifies the group number for the policyholder with the primary insurer.
TYPE	This field identifies the type of insurance (e.g., insurance or indemnity)

Field Name	Description
EMPLOYER INFORMATION	These fields are not utilized in DDE.

***NOTE**: HIQA Page 16 (Figure 81) reflects that it is Page 16 of 19. The total number of pages following Page 15 for an HIQA record will vary. If, as in this example, a beneficiary has more than one valid MSP record on the CWF, the pages that follow page 16 will provide the remaining insurance plans and information in the same layout as HIQA Page 16.

SECTION 9 – HEALTH INSURANCE QUERY FOR HHA

The Health Insurance Query for HHAs (HIQH) allows different types of institutional providers to inquire about a beneficiary and receive an immediate response about their Medicare eligibility based on available claims data. Since beneficiaries often move from home health to hospice care, both HHAs and hospices can employ HIQH as their single CWF inquiry transaction. HIQH, which includes the information made available in HIQA, gives Medicare providers direct access to the CMS's CWF Host database. Providers may query a Beneficiary's Master Record. The beneficiary's record contains Medicare entitlement, hospice benefit information, health maintenance organization (HMO) information, and other payer information. Each beneficiary record is located at one of nine CWF Host sites.

CWF edits claims for validity, entitlement, remaining benefits, and deductible status. A reply from CWF will be returned the following day. The majority of claims will be accepted by CWF for remittance. Others will reject, open for recycle at a later date, or suspend for investigative action.

The objectives of the CWF are to provide:

- Complete beneficiary information to Medicare contractors as—
  - Entitlement data
  - Utilization data
  - Claim history
- Information in a timely manner via an online process
- Accurate initial claims processing with—
  - Deductible access
  - Coinsurance access
  - Part A and Part B benefits paid comparison
  - Check editing prepayment (so contractor's approval equals CMS acceptance)
  - Duplicate payments prevention
  - Efficient implementation of future benefits and enhancements changes

Part A CWF Send Process

The Medicare contractor or satellite uses its best available information on beneficiary eligibility and remaining benefits to fully adjudicate claims. Every claim has been grouped, priced, and evaluated for Medicare Secondary Payer involvement and has its final reimbursement (including interest) before it is sent. High Speed ***bulk data transfer*** transmits the Medicare contractor paid claim to the host for approval. Prior to ***SEND***, the Medicare contractor converts adjudicated claims from in-house format to CWF format. This is known as the ***best shot*** approach for bill payment. Claims awaiting CWF transmission reside in status/location **S B9000.**

Part A Response Process

Palmetto GBA maintains a holding file containing claims awaiting an initial CWF response (**S B9099**). No manual transaction can be made against these claims. Claims cannot be finally adjudicated until a definitive response is received from CWF, unless a manual function instructs the system to process the claim without being transferred to CWF. Responses aid in processing and proper adjudication of Medicare claims. The responses Palmetto GBA receives from the CWF are:

- CWF Edit Error codes that tell us a CWF response is ready to be worked (a 5-digit code appears in the lower left corner of the UB04 screen).
- A CWF Disposition Code, a 2-digit category or status of claim, that indicates:
  - Claim is approved
  - Claim is rejected
  - Claims will be retrieved from history
- Alert codes, CWF requests for investigation of overlapping benefits and eligibility status.
- Approved claims, Medicare contractor produced provider check and remittance advice.

- Rejected claims that require further investigation. Medicare contractor reviews these claims, makes corrections, and resubmits them to CWF.
- Recycled claims, which recycle automatically, back to CWF. The FISS status/location definitions are:
  S B90_0 = 1st transmission
  S B90_1 = 2nd transmission
  S B90_2 = additional transmissions

CWF Host Sites

The Centers for Medicare & Medicaid Services maintains centralized files on each Medicare beneficiary with minimal eligibility and utilization data. Contractors query this file to process claims. **CWF** disperses the beneficiary files into **nine regional host sites**.

GL – Great Lakes	MA – Mid-Atlantic	SE – Southeast	GW – Great Western	
Illinois	Indiana	Alabama	Idaho	North Dakota
Michigan	Maryland	Mississippi	Iowa	Oregon
Minnesota	Ohio	North Carolina	Kansas	South Dakota
Wisconsin	Virginia	South Carolina	Missouri	Utah
	West Virginia	Tennessee	Montana	Washington
			Nebraska	Wyoming
PA – Pacific	**SO – South**	**KS – Keystone**	**NE – Northeast**	**SW – Southwest**
Alaska	Florida	Delaware	Connecticut	Arkansas
Arizona	Georgia	New Jersey	Maine	Colorado
California		New York	Massachusetts	Louisiana
Hawaii		Pennsylvania	New Hampshire	New Mexico
Nevada			Rhode Island	Oklahoma
			Vermont	Texas

HIQH Inquiry Screen

Once you have successfully logged onto the HIQH function, the CWF beneficiary inquiry area will display (Figure 82). To access a beneficiary's CWF Master Record, enter information into this screen.

HIQH Inquiry Screen – Field definitions and completion requirements are provided in the table following Figure 82.

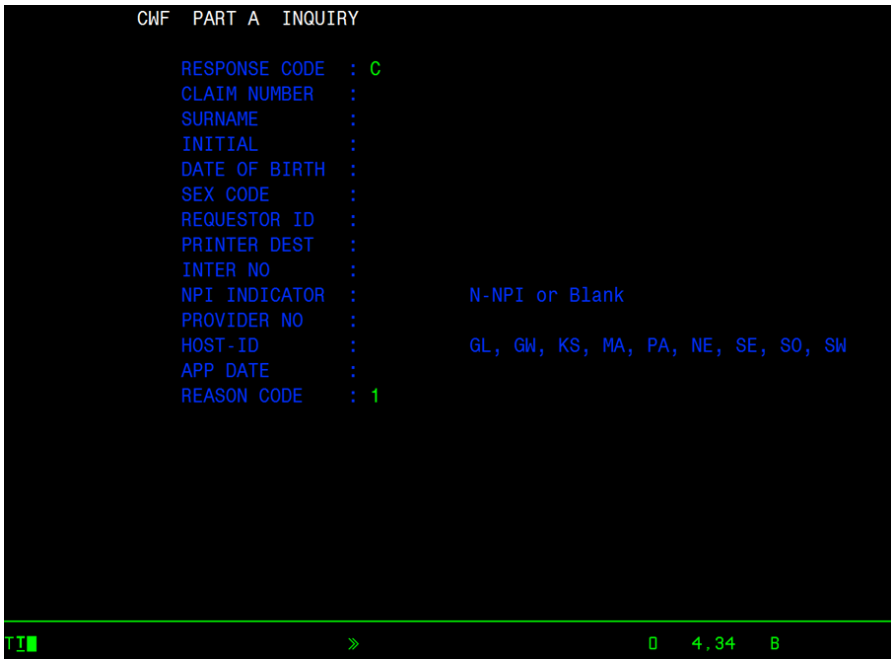


Figure 82 – CWF Part A Beneficiary Inquiry Screen

Field Name	Description
RESPONSE CODE	Data in this field (a 'C' for Display on CRT) is automatically inserted by the system.
CLAIM NUMBER	Enter the beneficiary's Medicare number as shown on the Medicare card in this field.
SURNAME	Enter the first six (6) letters of the beneficiary's last name.
INITIAL	Enter the first initial of the beneficiary's first name.
DATE OF BIRTH	Enter the beneficiary's date of birth in MMDDCCYY format.
SEX CODE	Enter the beneficiary's sex. Valid values are: F = Female M = Male
REQUESTOR ID	Identifies person submitting the inquiry or person requesting printed output. Enter '1' in this field.
PRINTER DEST	Leave this field blank (system default printer). This field is for the Printer device that the response will be directed to if a 'P' or 'E' is typed in the Response Code field.
INTER NO	Identifies the Medicare contractor processing the claim. Enter one of the following for a beneficiary in Palmetto GBA's jurisdiction: ▪ 11201 = Part A South Carolina ▪ 11501 = Part A North Carolina ▪ 11301 = Part A Virginia ▪ 11401 = Part A West Virginia ▪ 11004 = Home health or hospice
PROVIDER NO	The six-digit number assigned by Medicare to the provider rendering medical service to the beneficiary.
HOST-ID	Host IDs are shown as two-letter abbreviations for the nine CWF host sites. You should access the appropriate host and enter one of the following designations: GL = Great Lakes GL = Great Lakes GL = Great Lakes GW = Great West GW = Great West GW = Great West KS = Keystone KS = Keystone KS = Keystone
APP DATE	Date the beneficiary was admitted to the hospital in MMDDYY format. This field is not required. However, entering a date will allow for the most recent information to be provided.
REASON CODE	Indicates the reason for the inquiry. Valid codes are: 1 = Status Inquiry 2 = Inquiry relating to an admission A '1' is automatically inserted in this field by the system. Change this only if applicable.

HIQH Page 1 – Field definitions and completion requirements are provided in the table following Figure 83.

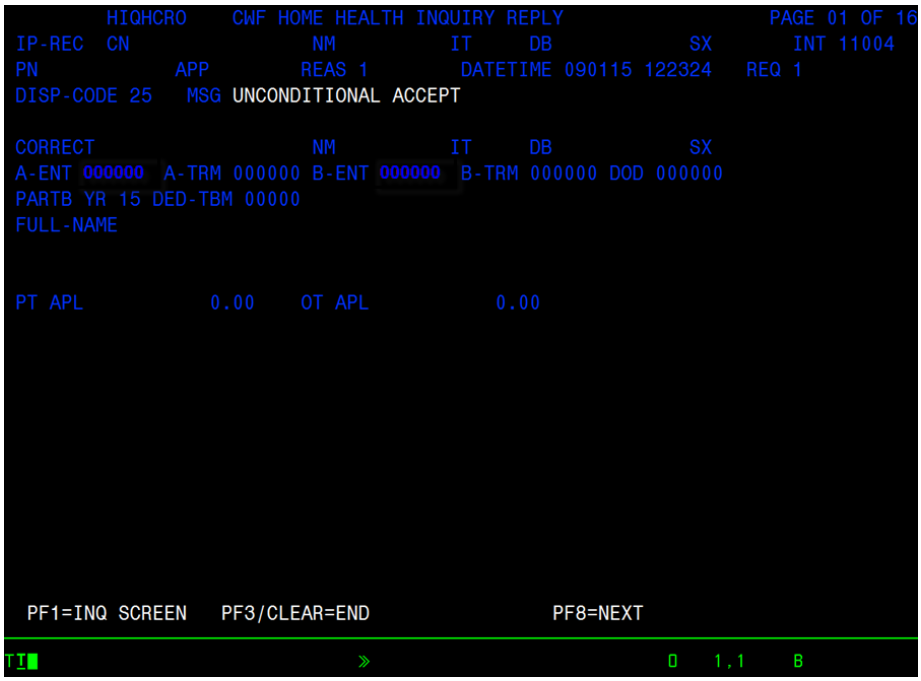


Figure 83 – CWF Part A Inquiry Reply Screen, Page 1

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
IN	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
PN	**Provider Number** – The agency's Medicare provider number.
APP	**Applicable Date** – Used for spell determination.
REAS	**Reason Code** – Indicates the reason for the inquiry.
DATETIME	**Date and Time Stamp** – date and time of the inquiry in Julian date format.
REQ	**Requestor ID** – auto populates
Disposition Code	Indicates a condition on a CABLE response. Valid values are: 01 = Part A Inquiry approved 02 = Part A Inquiry approved 03 = Part A Inquiry rejected 20 = Qualified approval but may require further investigation 25 = Qualified approval 50 = Not in file 51 = Not in file on CMS batch system 52 = Master record housed at another HOST site 53 = Not in file in CMS but sent to CMS's alpha-reinstate 55 = Does not match a master record ER = Consistency edit reject UR = Utilization edit CR = A/B crossover edit CI = CICS processing problem SV = Security violation
MSG	**Message** – The verbiage pertaining to the disposition code.

Field Name	Description
CORRECT	**Correct Claim Number** – Displays the beneficiary's correct HIC number. If the HIC entered in the inquiry screen (Figure 83) is different than the number in this field, this is the number you will use to submit claims.
NM	**Corrected Name** – This field displays the beneficiary's correct name. The name in this field will be different only if the name entered in the inquiry (Figure 83) screen is not consistent with CMS's record.
IT	**Corrected Initial** – This field displays the beneficiary's correct initial of the first name. The initial in this field will be different only if the initial entered in the inquiry screen (Figure 83) is not consistent with CMS's record.
DB	**Corrected Date of Birth** – This field displays the beneficiary's correct date of birth. The date of birth in this field will be different only if the date of birth entered in the inquiry screen (Figure 83) is not consistent with CMS's record.
SX	**Corrected Sex Codes** – This field displays the beneficiary's correct sex. The sex code in this field will be different only if the sex code entered in the inquiry screen (Figure 83) is not consistent with CMS's record.
A-ENT	**Part A Entitlement** – Date of entitlement to Part A benefits in a MMDDYY format.
A-TRM	**Part A Termination** – Indicates date of termination of Part A entitlement, when applicable, in a MMDDYY format. Otherwise, this field will display all zeros.
B-ENT	**Part B Entitlement** – Date of entitlement to Part B benefits in MMDDYY format.
B-TRM	**Part B Termination** – Indicates date of termination of Part B entitlement, when applicable, in MMDDYY format. Otherwise, this field will display all zeros.
DOD	**Date of Death** – If the beneficiary is alive, the field will be all zeros.
PART B YR	**Most Recent Part B Year** – From the applicable date input field.
DED-TBM	**Deductible To Be Met –** Amount of the Part B cash deductible remaining to be met for the current year.
PT APL	**Physical Therapy-** The amount applied to the physical therapy services provided in an outpatient setting.
OT APL	**Occupational Therapy** – The amount applied to the occupational therapy services provided in an outpatient setting.

HIQH Page 2 – Field definitions and completion requirements are provided in the table following Figure 84.

Figure 84 – CWF Part A Inquiry Reply Screen, Page 2

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
SPELL NUM	**Spell of Illness Number** – This number reflects the current home health spell of illness.
QUALIFYING IND	**Qualifying Stay Indicator** – This is a numeric field used to identify a qualifying A/B split hospitalization. Valid values are: 0 = No 1 = Yes
PART A VISITS REMAINING	The number of Part A visits remaining in the episode of care. Medicare Part A pays for the first 100 visits if a patient has a qualifying hospital stay, and if a patient is admitted to home health within 14 days of discharge. Medicare Part B pays for the remaining visits. In addition, Medicare Part B pays for all visits if there is no qualifying hospital stay (the patient must have Medicare Part B for Part B to reimburse for the services). If a beneficiary has Medicare Part A only, then Part A will pay for all of their services.
EARLIEST BILLING	The earliest date submitted for the spell of illness.
LATEST BILLING	The latest date submitted for the spell of illness.
PARTB VISITS APPLIED	The number of visits in the episode of care that were reimbursed by Medicare Part B.

HIQH Page 3 – Field definitions and completion requirements are provided in the table following Figure 85.

Figure 85 – CWF Part A Inquiry Reply Screen, Page 3

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
START DATE	**Start Date** – Shows the start date of the home health episode.
END DATE	**End Date** – Indicates end date of the home health episode.
INTER NUM	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
PROV NUM	**Provider Number**- The provider number of the home health agency that submitted the claim.
DOEBA	**Date of Earliest Billing Action** - the first service date of the HHPPS period.
DOLBA	**Date of Last Billing Action** - the last service date of the HHPPS period.
PATIENT STAT	**Patient Status Code** – the patient status code submitted in field 22 of the claim.
PATIENT IND	**Patient Indicator** – Valid values are: 0 = Episode in good status – Final Claim received on time 1 = RAP auto cancelled 2 = RAP not cancelled – Final Claim denied by Medical Review– Entire episode cancelled

HIQH Page 4 – Field definitions and completion requirements are provided in the table following Figure 86.

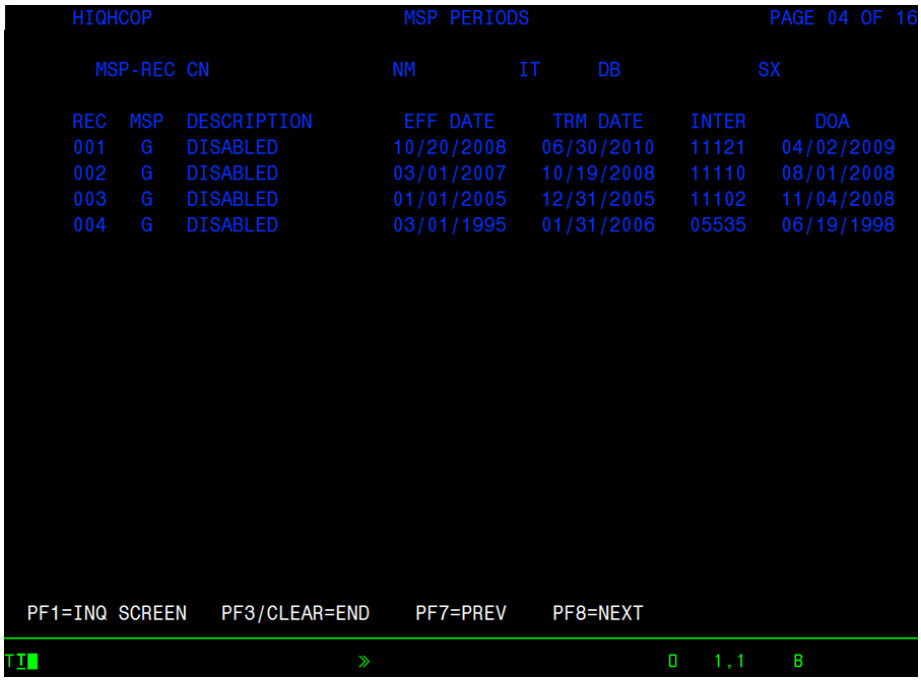


Figure 86 – CWF Part A Inquiry Reply Screen, Page 4

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
REC	**Record Number –** Identifies the MSP segment number.
MSP	**Medicare Secondary Payer** – Identifies the type of MSP record on file. Valid values are: A = Working Aged B = ESRD D = No-Fault E = Workers' Compensation F = PHS Other Federal Agency G = Disability H = Black Lung I = Veterans (VA) L = Liability W = Workers' Compensation set aside
DESCRIPTION	Type of primary insurance plan (Working Aged, Disabled, Workers Comp, etc.).
EFF DATE	**Effective Date** – The effective date of the primary plan.
TRM DATE	**Termination Date** – The termination date of the primary plan (if applicable).
INTER	The Medicare contractor number associated with the source of the MSP information.
DOA	**Date of Accretion** – the date the MSP record was established in CWF.

HIQH Page 5 – Field definitions and completion requirements are provided in the table following Figure 87.

Figure 87 – CWF Part A Inquiry Reply Screen, Page 5

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
PLAN TYPE	Medicare Advantage (MA) Plan (HMO) **Type** such as PPO.
PLAN ID	Medicare Advantage (MA) Plan (HMO) **Identification Code** – Valid values are: Position 1 = H 2 & 3 = State Code 4 & 5 = HMO Number within the state
OPT	MA Plan (HMO) **Option Code –**Describes the type of plan the beneficiary selected (risk or cost based). Valid values are: 1 or 2 = MA Plan to process bills only for directly provided services and for service from provider with whom the MA plan has effective arrangements. Palmetto GBA processes all other bills. C = MA Plan to process all bills.
EFF DATE	**Effective Date** – The effective date of the MA Plan.
TRM DATE	**Termination Date** – The termination date of the MA Plan (if applicable).

HIQH Pages 6 and 7 - Field definitions and completion requirements are provided in the table following Figure 89.

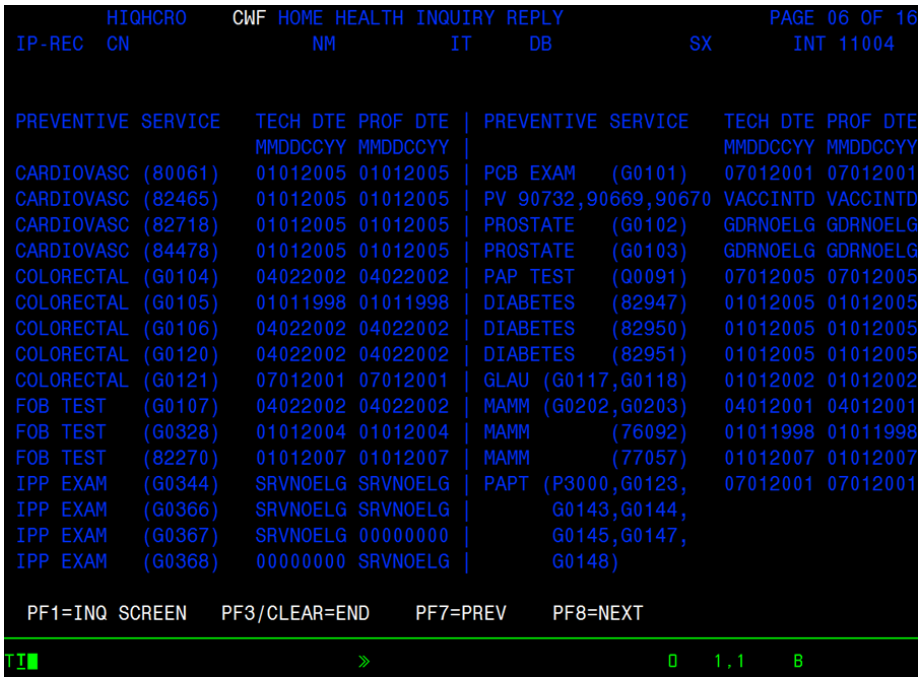


Figure 88 – CWF Part A Inquiry Reply Screen, Page 6

Figure 89 – CWF Part A Inquiry Reply Screen, Page 7

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.

Field Name	Description
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Preventive Services	
CARDIOVASC	Cardiovascular
COLORECTAL	Colorectal
FOB TEST	Fecal Occult Blood Test
IPP EXAM	Initial Preventive Physical Examination
PCB EXAM	Pelvic and Clinical Breast Examination
PPV	Pneumococcal Pneumonia Vaccine
PROSTATE	Prostate
PAP TEST	Pap Smear Test
DIABETES	Diabetes
GLAU	Glaucoma
MAMM	Mammography
PAPT	Pap Smear Test
AAA	Abdominal Aortic Aneurysm
AWV	Annual Wellness Visit
IPP EXAM	Initial Preventive Physical Examination
BLANK	Healthcare Common Procedure Coding System (HCPCS) code for the preventive service
TECH DTE	Next eligible technical date for the preventive service listed
PROF DTE	Next eligible professional date for the preventive service listed

The TECH DTE and PROF DTE may show abbreviations in the MMDDYYYY field. Some common abbreviations that may occur include:

- AGENOELG – Beneficiary not eligible due to age
- GDRNOELG – Beneficiary not eligible due to gender
- NOPTBENT – Beneficiary not entitled to Part B
- 00000000 – Service not applicable
- SRVNOELG – Beneficiary not eligible for the service
- VACCINTD – Beneficiary already vaccinated
- RECEIVED – Beneficiary already received the service
- DODNOELG – Beneficiary not eligible due to date of death

HIQH Pages 8 – Field definitions and completion requirements are provided in the table following Figure 90.

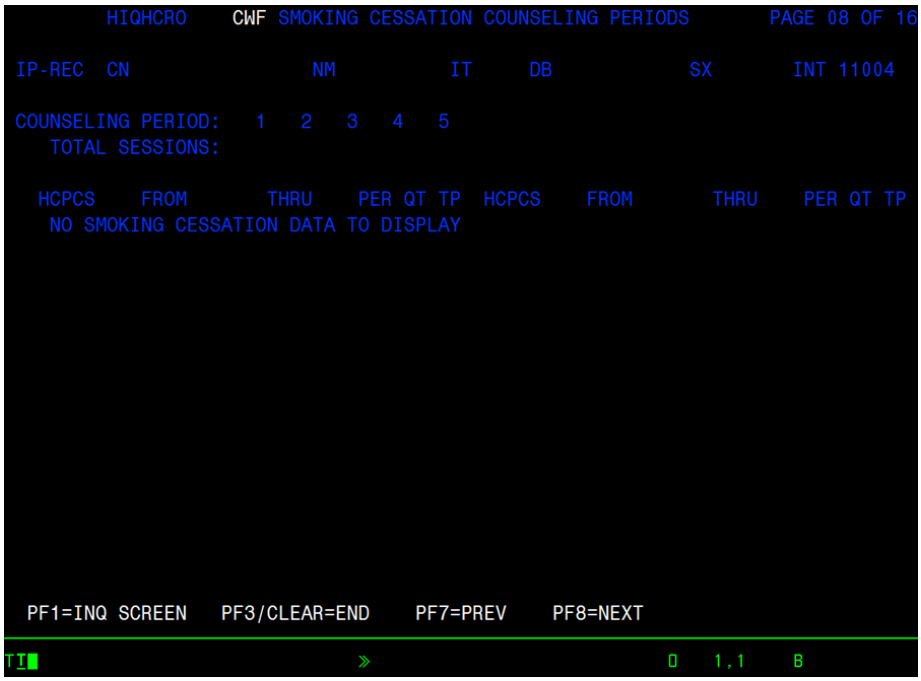


Figure 90 – CWF Part A Inquiry Reply Screen, Page 8

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
COUNSELING PERIOD	Identifies up to five years of counseling data. Valid values include '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
TOTAL SESSIONS	Identifies the number of sessions billed for the beneficiary.
HCPCS	HCPCS Code
FROM	From date of claim
THRU	Through date of claim
PER	Identifies up to five years of counseling data. Valid values include: '1' = one year '2' = two years '3' = three years '4' = four years '5' = five years
QT	**Quantity** – The number of services billed for each date.
TP	Claim type

HIQH Pages 9 and 10 – Field definitions and completion requirements are provided in the table following Figure 92.

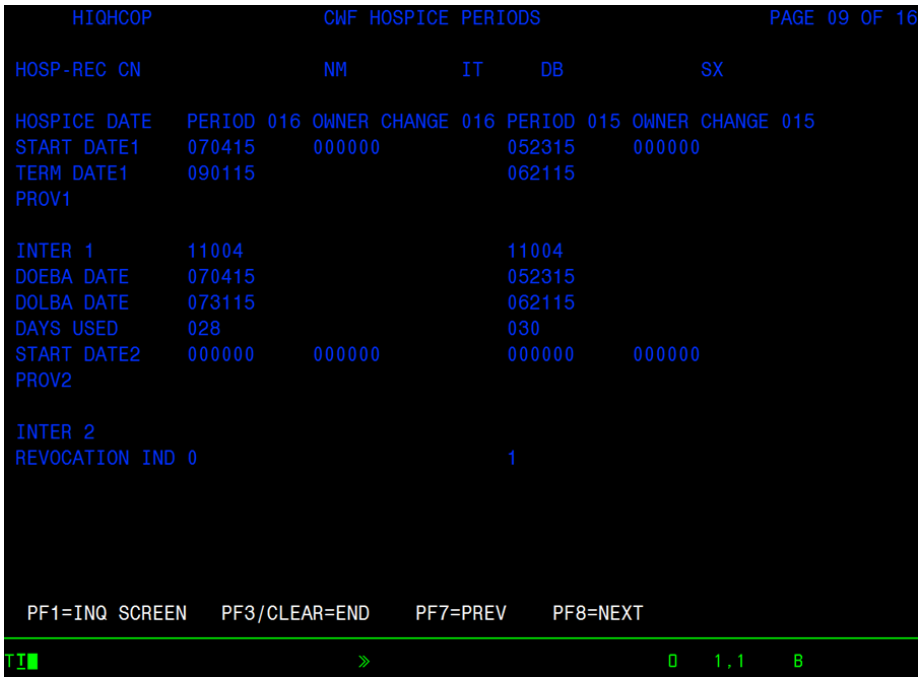


Figure 91 – CWF Part A Inquiry Reply Screen, Page 9

Figure 92 – CWF Part A Inquiry Reply Screen, Page 10

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.

Field Name	Description
HOSPICE DATA	Indicates if the beneficiary elected the Medicare hospice benefit.
START DATE1	The elected start date of a beneficiary's period of hospice coverage.
TERM DATE 1	Indicates the termination of the first hospice benefit period. May be listed as the end of the benefits for the hospice period indicated, or the revocation of hospice benefits.
PROV1	**First Provider** – first provider the beneficiary has elected for hospice benefits. This is the assigned Medicare provider number.
INTER1	**First Intermediary Number** – Indicator as to the Medicare contractor that is processing the Hospice claim.
DOEBA	Date of earliest billing action.
DOLBA	Date of last billing action.
DAYS USED	Lists the number of days used per benefit period.
START DATE2	Lists second start date if a beneficiary elects to change hospices during a benefit period.
PROV2	Indicates the Second provider number to submit hospice claims when a beneficiary chooses to change providers during a benefit period.
INTER2	**Second Intermediary Number** – Indicator as to the Medicare contractor that is processing the hospice claim if the beneficiary elects to change hospices during a benefit period that submits claims to a different contractor.
REVOCATION IND	**Revocation Indicator** – Indicates if a beneficiary has revoked hospice benefits for the period. Valid values are: 0 = Beneficiary has not revoked hospice benefits. 1 = Beneficiary has revoked hospice benefits. 2 = Beneficiary has revoked hospice benefits; record was manually updated by CWF at the request of the Medicare contractor.

HIQH Page 11 – Field definitions and completion requirements are provided in the table following Figure 93.

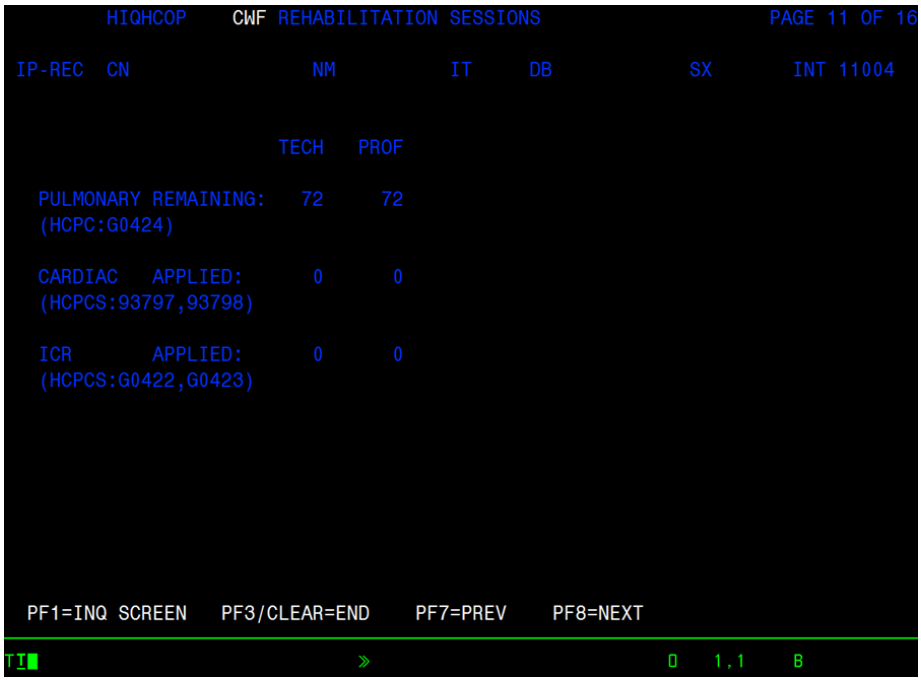


Figure 93 – CWF Part A Inquiry Reply Screen, Page 11

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TECH	Technical
PROF	Professional
PULMONARY REMAINING	The total number of technical and professional Pulmonary Rehabilitation services remaining.
CARDIAC APPLIED	The total number of professional and technical Cardiac Rehabilitation services used.
ICR APPLIED	The total number of professional and technical Intensive Cardiac Rehabilitation services used.

HIQH Page 12 – Field definitions and completion requirements are provided in the table following Figure 94.

Figure 94 – CWF Part A Inquiry Reply Screen, Page 12

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
REC HCPCS	**Record HCPCS** – Identifies the HCPCS filed.
FROM DT	**From Date** – The home health certification from date.

HIQH Page 13 – Field definitions and completion requirements are provided in the table following Figure 95.

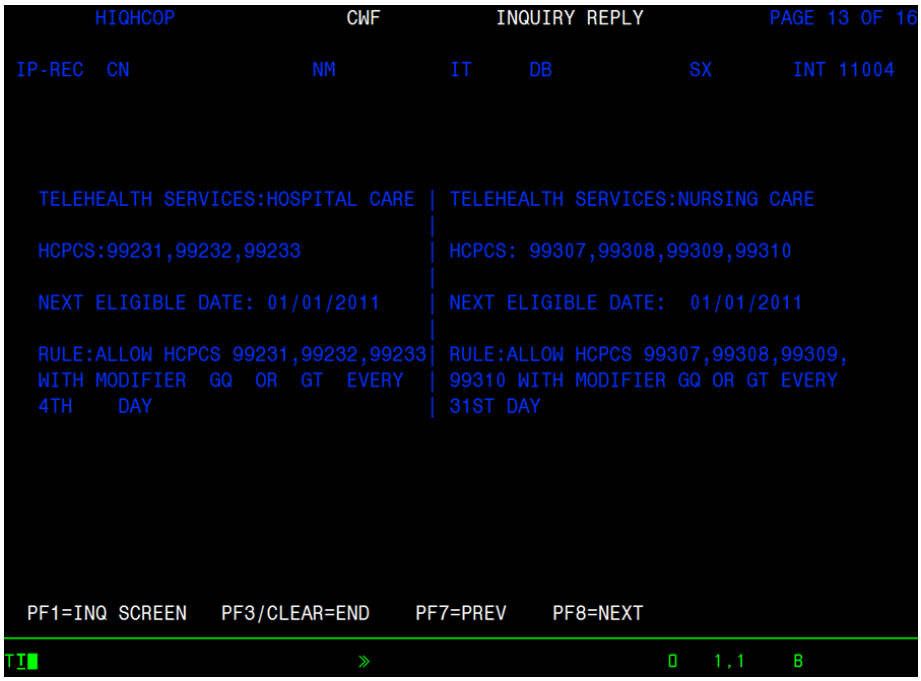


Figure 95 – CWF Part A Inquiry Reply Screen, Page 13

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
TELEHEALTH SERVICES: HOSPITAL CARE	Telehealth services rendered under hospital care.
TELEHEALTH SERVICES: NURSING CARE	Telehealth services rendered under nursing care.
HCPCS	The HCPCS codes billed.
NEXT ELIGIBILE DATE	The beneficiary's next eligible date for services.
RULE	The Allowed HCPCS, with modifier and how often.

HIQH Page 14 – Field definitions and completion requirements are provided in the table following Figure 96.

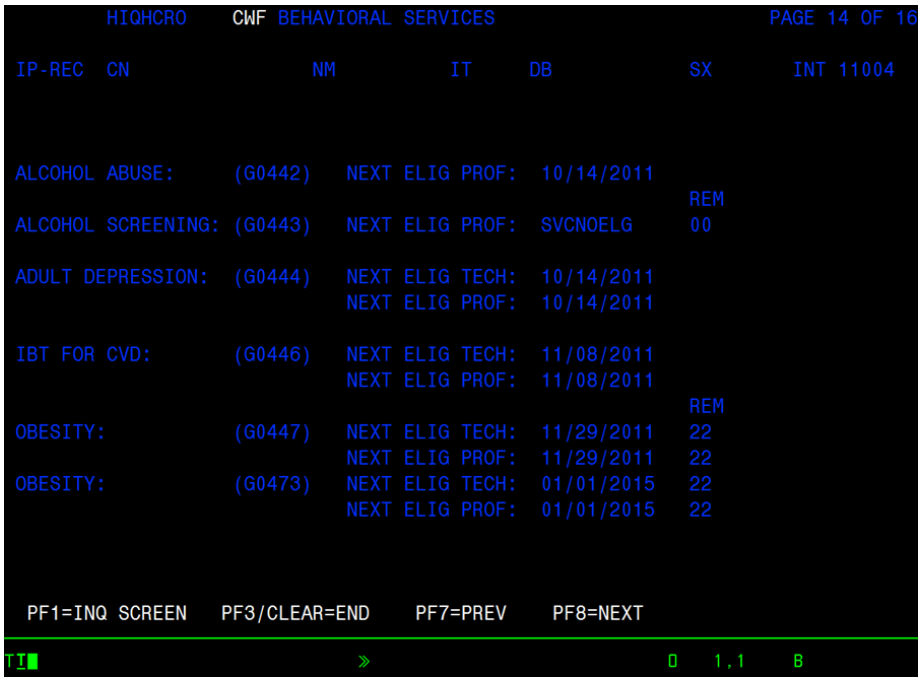


Figure 96 – CWF Part A Inquiry Reply Screen, Page 14

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
ALCOHOL ABUSE	This field identifies the HCPCS code billed for Alcohol abuse screening.
ALCOHOL SCREENING	This field identifies the HCPCS code billed for a face-to-face behavioral counseling for alcohol misuse.
ADULT DEPRESSION	This field identifies the HCPCS code billed for the annual depression screening.
IBT FOR CVD OBESITY	This field identifies the HCPCS code billed for **Intensive Behavioral Therapy (IBT) for Covered (CVD) Obesity**.
NEXT ELIG TECH	**Next Eligible Technical Date** – This field identifies the next date the patient is eligible for the technical component of the screening.
NEXT ELIG PROF	**Next Eligible Professional Date** – This field identifies the next date the patient is eligible for the professional component of the screening.

HIQH Page 14 – Field definitions and completion requirements are provided in the table following Figure 97.

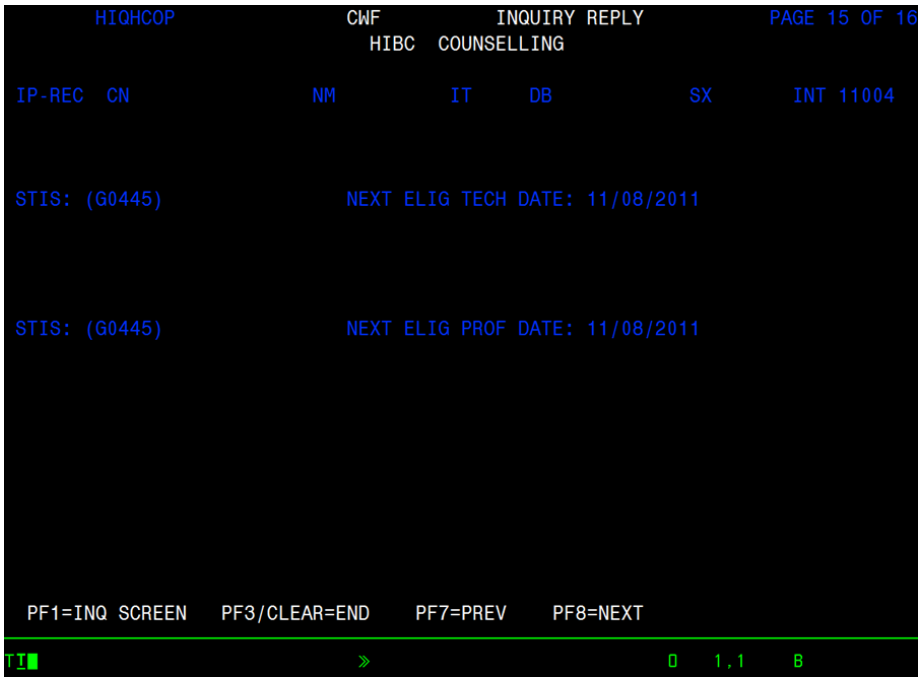


Figure 97 – CWF Part A Inquiry Reply Screen, Page 15

Field Name	Description
High Intensity Behavioral Counseling (HIBC) Counselling	
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
STIS	**Sexually Transmitted Infections** – This field identifies the codes billed for STI screening.
NEXT ELIG TECH DATE	**Next Eligible Technical Date** – This field identifies the next date the patient is eligible for the technical component of the screening.
NEXT ELIG PROF DATE	**Next Eligible Professional Date** – This field identifies the next date the patient is eligible for the professional component of the screening.

HIQH Page 14 – Field definitions and completion requirements are provided in the table following Figure 98.

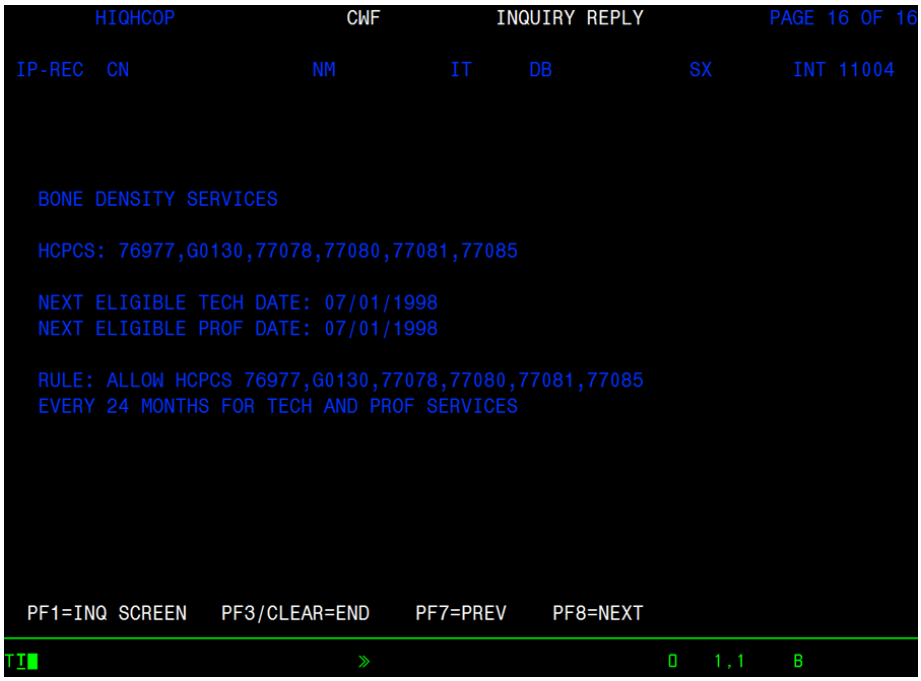


Figure 98 – CWF Part A Inquiry Reply Screen, Page 16

Field Name	Description
CN	**Claim Number** – Shows the beneficiary's HIC number.
NM	**Name** – Shortened form of the beneficiary's surname (last name).
IT	**Initial** – First letter of beneficiary's first name.
DB	**Date of Birth** – Beneficiary's eight-digit date of birth (MMDDCCYY).
SX	**Sex** – Beneficiary's sex code.
INT	**Medicare Contractor Number** – The provider's Medicare contractor (e.g., Palmetto GBA).
Bone Density Services	
HCPCS	This field identifies the HCPCS codes billed for the bone density services.
NEXT ELIGIBLE TECH DATE	This field reflects the next eligible date for the technical component of the bone density services.
NEXT ELIGIBLE PROF DATE	This field reflects the next eligible date for the professional component of the bone density services.
RULE	This field identifies the allowable HCPCS codes and how often for the bone density services.

APPENDIX – ACRONYMS

Acronym	Description
A	
ACS	Automated Correspondence System
ADR	Additional Development Request
ADJ	Adjustment
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center
ANSI	American National Standards Institute
B	
C	
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMG	Case-mix Group
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CO	Contractual Obligation
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CWF	Common Working File
D	
DCN	Document Control Number
DDE	Direct Data Entry
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSH	Disproportionate Share Hospital
E	
EDI	Electronic Data Interchange
EGHP	Employer Group Health Plan
EMC	Electronic Media Claims
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
F	
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
FQHC	Federally Qualified Health Centers
G	
H	
HCPC	Healthcare Common Procedure Code
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
HICN	Health Insurance Claim Number
HIPPS	Health Insurance Prospective Payment System (the coding system for home health claims)
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRR	Hospital Readmission Reduction
HSA	Health Service Area
HSP	Hospital Specific Payment
HSR	Hospital Specific Rate
I	
ICD	Internal Classification of Diseases
ICN	Internal Control Number
IDE	Investigational Device Exemption
IEQ	Initial Enrollment Questionnaire
IME	Indirect Medical Education
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
J	
K	
L	
LGHP	Large Group Health Plan
LOS	Length of Stay
LTR	Lifetime Reserve days
M	
MA	Medicare Advantage Plan
MAC	Medicare Administrative Contractor
MCE	Medicare Code Editor
MR	Medical Review
MSA	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
N	
NDC	National Drug Code
NIF	Not in File
NPI	National Provider Identifier
O	
OCE	Outpatient Code Editor
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
ORF	Outpatient Rehabilitation Facility
OSC	Occurrence Span Code
OTAF	Obligated To Accept in Full
OT	Occupational Therapy
P	
PC	Professional Component
PHS	Public Health Service
PPS	Prospective Payment System

Acronym	Description
PR	Patient Responsibility
PRO	Peer Review Organization
PS&R	Provider Statistical and Reimbursement Report
PT	Physical Therapy
Q	
R	
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return To Provider
S	
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SLP	Speech Language Pathology
SMSA	Standard Metropolitan Statistical Area

Acronym	Description
T	
TC	Technical Component
TOB	Type of Bill
U	
UB	Uniform Billing
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
URC	Utilization Review Committee
V	
W	
X	
X-Ref	Cross-reference
Y	
Y2K	Year 2000
Z	